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THE PHENOMENOLOGY OF WOMAN TO MOTHER: THE TRANSFORMATIVE EXPERIENCE OF CHILDBIRTH

by

VANGIE BERGUM

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(SIGNED) Vangie Bergum

PERMANENT ADDRESS:

10922 - 126 st.
Edmonton, Alberta
Canada T5M 0P3

DATED September 1986

THE UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled THE PHENOMENOLOGY OF WOMAN TO MOTHER: THE TRANSFORMATIVE EXPERIENCE OF CHILDBIRTH submitted by VANGIE BERGUM in partial fulfilment of the requirements for the degree of DOCTOR OF PHILOSOPHY in DEPARTMENT OF SECONDARY EDUCATION.

M. van Manen

Supervisor

Robert Burch

Peggy Anne Field

Dyane D. Affonso

External Examiner

Date June 23 1986

DEDICATION

To Mothers

In memory of my mother,
Edna Bergum Vinge

And Daughters

For my daughter,
Siri Nina Bergum Kelpin

ABSTRACT

The focus of this research is the exploration of the transformative moments that women experience as they become mothers through bearing, birthing, and caring for children. Women come to this experience with different expectations and desires based on their personal histories and on the information and knowledge passed on to them from their own mothers, from friends, from books and films, as well as from professionals such as nurses, midwives, doctors, and scholars. Birthing information available to women is based on various knowledge forms which influence how women come to understand themselves as they become mothers. The prevailing understandings of the nature of birth are based on obstetrical knowledge gained through scientific research and technological advances. In this study, these understandings were contrasted with knowledge approaches of the traditional lay midwife, the professional midwife, childbirth educators, and social critics which include philosophers, feminists, etc. Analysis of these forms of knowledge formed the ground for the question of the research: How does the experience of childbirth transform a woman to mother? That is, what is the nature of a woman's transformation to mother?

The present research uses a phenomenological approach of which hermeneutics is an integral part. The study is centred around conversations with six women who describe their experiences of pregnancy, childbirth, and the first months of living with a child. On the basis of these conversations stories were written to reveal the unique nature of each woman's experience. Each narrative seemed to uncover a theme or moment of the transformative nature of the woman's experience of childbirth. These moments were found in other women's experiences as well. The transformative moments described and interpreted in this study include: the decision to have a child; the experienced presence of the child; the separation of mother/child which may lead to integration and wholeness; the appropriation of responsibility for oneself and the world as one accepts the presence of the child; and the mind-ful-ness to the child that occurs with a child in one's life. These transformative moments were woven into the existential themes (temporality, spatiality, corporeality, and relationship) in an attempt to create a fabric which describes and captures the transformative process. In the writing, these moments appeared again and again,

building on one another in an attempt to achieve a deeper integration throughout. The reflective interweaving of the thematic moments was performed on the basis of insights gleaned from the women's stories as well as from the transcripts, from literature and artistic sources, from commonly used phrases, from etymology, and from personal experience. The phenomenological writing was, in a sense, a creative work which attempted to show an understanding of a woman's transformation to mother.

The thrust of the work is to invite conversation among those involved in childbirth so that further research will consider the transformative nature of this experience for women. A number of theses resulting from the research are offered as a way to continue conversation among women, nurses, midwives, doctors, childbirth educators, and others involved in the care of women and babies during this important event.

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This work would never have been undertaken or accomplished without the support of family and friends, faculty and students in the Department of Secondary Education, and the women who participated.

Throughout the work my husband, Brault Kelpin, stood beside me with words and action which clarified my thinking, reminded me of my task, and demonstrated his care for me. My children, Sem and Siri, not always understanding my need to do this work, rejoiced in my successes and observed and remained steady during my discouragements. The births of these children, and their impact on my life, have made it possible for me to do this work.

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Chapter 1

ESTABLISHING THE GROUND FOR THE QUESTION

Introduction

> The deciding of the question is the way to knowledge. (Gadamer, 1977, p. 328)

> To hit on the problem is the first step to any discovery or indeed to any creative act. To see a problem is to see something hidden that may not be accessible. The knowledge of a problem is, therefore, like the knowing of unspecifiables, a knowing of more than you can tell. (Polanyi, 1969, p. 131)

> The closer we come to the danger, the more brightly do the ways into the saving power begin to shine and the more questioning we become. For questioning is the piety of thought. (Heidegger, 1977b, p. 35)

The first, and perhaps fundamental, task of any dissertation is to find a question or problem worthy of pursuit as it points the direction of the work. The word "question" comes from the Latin root word *quaerere* meaning "to seek, to ask, to inquire, to be in the quest of something." Questioning indicates the existence of an unsettled issue, a difficult matter, an uncertainty, a matter for discussion. It also invites a reply, a dialogue, a searching out of opposites and similarities. It opens possibilities, and leads, in some sense, to uncertainty, for it throws what may have been thought secure into disequilibrium or imbalance. If questioning points the way the importance of the "right" question is paramount.

Questions about being a mother, that is, living as a mother in our present society, have surfaced again and again for me. First perhaps, though not easily articulated, was the coming to an understanding of the importance of my mother to me. My interest in mothering persisted as a hospital nurse with women in labour and post-partum; as a career woman wondering about the possibility of children in my own life; as a married woman waiting the birth of my child; as an educator preparing other women for childbirth; as a feminist thinking about women as mothers; as a friend attending other birthing women both at home and in hospital; as a researcher seeking for a way to ask useful questions; and as a mother at my desk in the dining room, that is, living with children. So I find myself deeply interested in mothers and mothering with the questions about the meaning of being a mother coming back to me, pressing themselves on me. This kind of involvement in research is what Marcel (1978) calls "second reflection," where there is no detachment. "First reflection" research is "an act of alienation and desertion with the seeking the ideal non-involvement of the reseacher" (Zaner, 1971, p. 7).

In order to disclose the question of this dissertation the present situation of women in the process of childbearing and mothering must be made clear. In this chapter, I will explore the present situation of the childbearing woman to show the need for the question that will be posed. In chapter 2, I will describe the approach used study the question. The first two chapters, then, lay the groundwork for the substantive work of chapters 3-9. A number of theses resulting from this research are offered in Chapter 10 as a way of concluding this work.

The Situation of the Childbearing Woman

To live as a woman today is to live in a time of change. Women's voices are being heard as they have never been heard before. This is not because women are just now beginning to speak or because they now have something to say; they always have. It is not because women's words are coming with more clarity; for years women have spoken with profound depth and understanding. It is not because they speak from a consensus of all women; women see the world from individual perspectives. Rather it is that only now women are being heard. Perhaps there is even a public recognition that our society is at risk and that women have something to say that is important to our survival as humans (Morgan, 1977, 1984). For whatever reason that women today speak, many are speaking about their social situations in the private realm (O'Brien, 1981, p. 208), and from a reality of childbearing and mothering (Chesler, 1979). Whether or not the women are actually mothers, the concerns are often centered around the "mothering" aspect of women's lives (Daly, 1978; O'Brien, 1981, Chicago, 1985). They speak to make their private worlds a public concern in areas such as equal pay for work of equal value, child care facilities, peace and non-violence, humane hospitals and home births, pro-choice or anti-abortion, pensions and family allowances, erotica rather than pornography, or sometimes simply for a woman to have "a room of her own" (see Morgan, 1984).

There is a questioning by women of the relevance of male views of the world for women (O'Brien, 1981; Daly, 1978; Miller, 1976). There is a questioning of the nature of the institution of motherhood (Rich, 1976; Arms, 1975; Rothman, 1982). There is a questioning of the view of child care as the primary responsibility of the mother (Dinnerstein, 1977; Chodorow, 1978; Ruddick, 1983). There is concern with women who, for whatever reason, work outside of the home (Oakley, 1980; Russell & Fitzgibbons, 1982)). Even the question to have children at all is now open to reflection (Dowrick & Grundberg, 1980; Trebilcot, 1983). Women are also learning about their own bodies and in so doing are generated by energy that leads to an exploration of all aspects of their lives. "Learning to understand, accept, and be responsible for our physical selves," say women, "we can be better friends, better lovers, better people, more self-confident, more autonomous, stronger, and more whole" (Boston Women's Health Book Collective, 1973, p. 3).

When women speak, simply as women, about childbearing and mothering they do so amidst a clamour of other voices: nurses, childbirth educators, medical doctors, sociologists, psychologists, and other scholars. What distinguishes these women's voices from the experts (be they women or men) is that the women tend to speak from their own experiences of how they live in this world as childbearing women and mothers. One has only to review the current popular books about pregnancy and childbirth available to the childbearing women (see ICEA *Bookmarks*, May, 1986), skim the medical and nursing textbooks (Clark & Affonso, 1976; Field, 1984; Pritchard, MacDonald, & Gant, 1985), investigate what childbirth educators are teaching (Kitzinger, 1979; Simkin, Whalley, & Keppler, 1984) or read recent feminist literature (Daly, 1978; O'Brien, 1981; Oakley, 1984; Morgan, 1984; Corea; 1985) to know that differing opinions about the childbirth experience abound.

There are those who think birth should happen at home; others feel that the hospital is the place of birth. Some want minimal use of technological or professional intervention; others accept both without any hesitation. Some want a midwife to support, guide, and help with birthing the baby; others want an obstetrician or a general practitioner to be present at the delivery. Some feel that women should be in control, that is, to have the responsibility to make the decisions which affect themselves and their babies; others feel that professionals have the rights and obligations to make the decisions. Some use human satisfaction as a criterion to judge the outcome of childbirth; others cite mortality and morbidity statistics in the evaluation. Some women see childbirth as a disruption in their lives and other women feel that it is a peak experience which profoundly changes the very core of their being. Some see a need to free women from the shackles of childbirth and mothering; others see the possibility of childbirth as an important celebration of femininity—the very strength of being female.

Perhaps the question of "whose birth, whose body, whose baby is it?" (Shearer, 1985) is the central issue. Of course, one could say, it is the woman's birth and the baby's, but is the baby not also born to the father, the doctor, the nurse, the hospital, the childbirth educator, society, or even the court? Of these interested parties whose knowledge does one respect? Who has the better opinion? What is right or good? How does a childbearing woman know how to act?

Approaches to Childbirth Knowledge

The situation in present society shows the complexity and confusion that childbearing women face. In order to clarify this confusion I will now focus on the differing approaches to childbirth knowledge. Two women's evocative descriptions of the birth of their first children exemplify the application of differing knowledge and opinions. Gail's daughter was born in a large, tertiary care hospital in Tanzania. Gail was admitted to that particular hospital because of the possibility of obstetrical complications. Reflecting on the last moments of labour, she said:

> Then the team gathered around .. all women, three midwives, two nurses and they were incredible! There were no stirrups, right! It was all hands-on! Everyone had some part of me. One was holding one leg, one was holding the other leg. I was held by all these women, and I remember only minutes before the last, all of us just laughing. Them joking about something. Just before the last contraction grabbed me, I had to stop myself from this big laugh that I was in. It just seemed that there was just so much gaiety—that only a whole collection of women together like that could really see the humour of that moment. There was something about the magic of that last bit of time, and then, she was born. Then my baby was born. Who would have thought, who can think that actually delivering a baby, painful, well yes, can actually be kind of fun.(G)[1]

The next anecdote comes from Christine's birthing experience in a large Canadian city hospital. She had been in labour for many hours and her baby son was soon to be born.

> Then things got really busy, seems to me there were three nurses, and there was another doctor assisting with the birth, and Dr. Henry gave me a pudendal block, and I remember knowing what that was, seeing a picture in the textbook, and that was all right. I was in stirrups and they had put the green things on, and were very busy, and everyone was

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[1] See Appendix A for coding of the interview data. All names have been changed to protect anonymity.

> draping me with stuff. I was thinking about the pudendal block and the nerves it hit. It hurt a bit, not really bad, very quick. And then they gave me a local down towards my anus, and that really hurt, hurt more than anything. I was still not looking at anyone, not looking at Dr. Henry, not seeing the forceps. I know I had my eyes open but I don't remember seeing anyone, and he said, "With the next contraction, I want you to push, I have the forceps on, and I want you to push." I didn't feel him put them on, didn't feel a thing when they were applied. Then Nathan [husband], and the nurses told me, at the same time, that there was a contraction and I started to push and that was the worst thing I have ever felt in my entire life (laughs). I just felt that everything was being pulled and yanked. The pain was so excruciating, I stopped pushing, and I think everybody . . . Dr. Henry said, "Christine, push," and I can remember him being louder than I had ever heard him. And Nathan said, "Push now," and then what happened was that everything stopped because I stopped pushing. My legs went straight out of my hip (I think I bonked the resident with my foot), my feet went out, and I yelled and yelled and said, "I can't push, it hurts." I must have pushed a little bit more and then Dr. Henry told me I was to "push the baby out on my own." He had taken the forceps off and the baby was born. . . . They finished with a zillion stitches, I'm sure. And then he (the doctor) came to my side and said, "Boy, I don't ever want you to do that to me again,"—that is what he said to me. (C3)

Of course there are a number of aspects which would influence these experiences, such as the position of the baby, the energy of the mother, the length of the labour, the differing cultures, and the hospital policy, but what must also be recognized is that implicit in these influences is the application of knowledge.

In the one situation one senses the closeness, the touch of women, who brought their skill, humour, and knowledge to assist the birthing woman to relax and open herself to the birth of her child. Perhaps in their wisdom these carriers of childbirth knowledge intuited the connection between the relaxed, laughing woman and the relaxed and flexible perineal muscles. Their practices showed thoughtful support for Gail to birth her own child. In the other situation one senses the effort made to prevent infection (the green drapes), to prevent pain (by inflicting pain), with the doctors, nurses, and husband using their knowledge and understanding in directing the experience, even to the point of telling Christine when her contractions were occurring (information available through the fetal monitor). The doctor's comment to Christine after the birth tells something about whose baby it was and whose experience was central. Yet both experiences resulted in the birth of a healthy, living child and mother. So what is at stake? What is the problem? Is there a problem?

When I was a young girl of perhaps twelve or thirteen, I read Pearl Buck's *The Good Earth*. When O-lan, the wife of Wang Lung said to her husband, "I am with child," I was intrigued. I was drawn back to those descriptions of birth a number of times. This was O-lan's first child.

> She would have no one with her when her hour came. . . . She said no word. . . . The panting of the woman became quick and loud, like whispered screams, but she made no sound aloud . . . [then] a thin, fierce cry came. . . . She called him in. The red candle was lit and she was lying neatly covered upon the bed. Beside her, wrapped in a pair of his old trousers, as the custom was in this part, lay his son. (Buck, 1931, pp. 37-39).

In this society women no longer give birth squatting over an old tub they keep for that purpose. They no longer creep around the room afterwards to remove traces of the birth, like an animal does. They no longer hide the bucket of blood under the bed so no one will see. They no longer say with the birth of the girl-child, "It is over once more. It is only a slave this time—not worth mentioning" (p. 62). O-lan gave birth in the tradition of her time. She gave birth as she understood herself and her life. She was a good woman. Childbirth was her responsibility.

Gail and Christine gave birth under the influence of the present tradition of childbirth knowledge. It is true that their experiences are just particular instances making generalization impossible. That is, however, not the point. The point is, rather, to show the need to analyze the underlying forms of knowledge that lead to particular application. Such an analysis places the forms of knowledge in the foreground so that one is able to see what is at stake, that is, what interests privilege particular approaches to knowledge. It is necessary to acknowledge that any analysis comes from within a frame of reference, a way of thinking, which one cannot step outside. I will explore both the *strengths and problems* associated with the various approaches to childbirth knowledge from a critical stance that arises from being a woman at this time in our history.

The effort in this analysis will be to go beyond documentation or reiteration of chronological facts of history. It will also go beyond attacking and rejecting these knowledge traditions, or even taking sides, for that blinds one to what is at stake. Rather the approach, as Arendt (1961) argued, aims to "be responsible for the world of tradition" in which we are situated. Being responsible recognizes that we belong to tradition in that we are shaped by the past. The challenge is to appropriate it while being critically aware of the modes of thought that constitute this tradition, and then articulate a just and viable tradition more appropriate to our present situation (Ruether, 1983; Elshtain, 1982).

Present forms of childbirth knowledge can be categorized in the following way: obstetrical, midwifery, methodological and critical. At present, obstetrical knowledge is the foundation of maternity care to which the other forms of knowledge have responded. Midwifery knowledge, while once the backbone of care, is now making a resurgence as it is being shown to be a knowledge form that is valuable to women. Methodological approaches arise from need to give tools to women to handle their own situation. The critical approach questions obstetrical, methodological, and midwifery knowledge from a number of viewpoints, including social, technological, and feminist perspectives.

The Obstetrical View

Strengths. The science of obstetrics has brought greater safety to the childbirth experience. Mortality rates show a dramatic decrease in recent years. The perinatal mortality rate of 20-30 per 1000 in 1970 is now close to 10 per 1000; the rate of infant death in the city of Edmonton decreased from a rate of 48.9 per 1000 in 1930 to 8.9 per 1000 in 1984 (ELBH, 1984). Health and safety of the mother and baby are the foundational factors underlying the management of childbirth practice in Canada. There can be no taking of risk when life is at stake.

Development of technology and the emphasis placed on scientific research in medicine have played an important role in this move to safer childbirth. Ultrasound is used as a diagnostic tool in pregnancy to assess the growth of the fetus, to search for abnormalities (such as a pelvic mass), or to identify problems with the placenta, etc. It is also used in fetal monitors which have made it possible for experts in major centers to give advice to practitioners in rural hospitals (Tucker, 1978). Episiotomies are performed to prevent unnecessary tearing of perineal tissues during delivery, to prevent loss of tone in the pelvic muscle, and to prevent damage to the newborn by shortening the second stage of labour (Thacker & Banta, 1983). Artificial rupture of the membranes, drugs, and forceps are used to assist and/or initiate the process of labour. The incidence of Cesarean sections, now considered a safe surgical procedure, has greatly increased in the last ten years, from 4-6 percent in 1974 to 15-17 percent in 1982 (even to 30 percent in some tertiary care hospitals) (Elkins, 1982, p. 2). In some situations women are even beginning to choose Cesarean births for they dare not risk a vaginal birth (K2).

Scientific obstetrics takes place in hospitals where medical experts with access to sophisticated equipment stand near at hand to respond immediately to any problem that may arise. At present over 97 percent of women in Canada and the United States have hospital births. Women are encouraged to be active in the early stages of labour and are often placed in the lithotomy position with the use of stirrups for delivery. This allows the doctor access to the perineal area in order to perform the episiotomy, to use forceps, and to employ other maneuvers if the necessity arises. Flexibility of birthing position has developed in some hospitals. Sterile technique used to prevent infection carries with it the admonition "to look but not touch" as the baby is born. Procedures such as intravenous infusion, enema, perineal shave, and attachment of the fetal monitor, vary from being initiated routinely to being used only in selected cases, depending on the skills and preferences of the doctor. The science of obstetrics approaches childbirth as a process to be initiated and monitored so that the course and outcome can be carefully controlled (Böhme, 1984).

As with any knowledge form that becomes very specific and technical, knowledge used in the management of childbirth has become confined to experts, the doctors and hospital staff (Berger & Luckmann, 1967, pp. 79-92). Such knowledge is controlled and legitimated from within. Professional groups develop their own methodologies and logics to insure safe practice. For example, in 1981 the Alberta College of Physicians and Surgeons banned physicians from attending births at home in the interests of safety.

Scientific, technological knowledge of childbirth has gained rapid support since the turn of the century which led to a move from home to hospital care and from care given by a midwife to care by a family doctor and obstetrician (Wertz & Wertz, 1979; Ehrenreich & English, 1979; Barrington, 1985, chap. 2; Shorter, 1982). So universal is the acceptance of medical opinion that many women have come to understand it as the absolute truth. Fundamental trust is placed in the doctor. Some women say gratefully, "we owe the lives of our children to them," others say, "the experience for me doesn't matter as long as my baby is healthy," or "one forgets the pain." Childbirth under the dominion of obstetrical knowledge is now the common, taken-for-granted attitude for many women. Reliance on the doctor as the carrier of that knowledge is sensed in Christine's comment just after being admitted to hospital. "They got me comfortable," she said, "Dr. Henry was on the floor. I heard his voice right away, and I guess he had had another baby, and that was very comforting" (C3).

Problems. Comforting, yes, . . . and yet? On August 26, 1985, Canada's national radio open-line show asked its listeners to respond to the question, "Should doctors be the only ones to deliver babies?" The question, itself, is a curious one. O-lan had no one with her—she gave birth to her child alone. Nowadays, many woman want and expect someone to help them. The problem comes with the helper. Does the helper take over the process so extensively that he or she "has" the baby? Is this loss of status of women as reproducers due to the fact that women have lost the knowledge once available to them to trust their own bodies? Or is it because women have accepted the underlying opinion that a medicalized birth is safer, and therefore give themselves over to that authority? Or, conversely, could it be that the separation of birth from the social context has led to a situation where childbirth is, in one sense, outside women's domain?

There are other voices as well. Women are saying that certain procedures such as the perineal shave is degrading, some say that the hospital is cold and mechanized, and some say that the dependency on medical specialists is disabling. Haire (1974) challenged current medical practices, such as the routine use of drugs, the hospital as a suitable environment, ambivalent breast feeding counselling, separating mothers and babies at birth, and many other routine practices. While women agree that safety is important they are beginning to question how safety can be considered outside of the whole context and meaning of giving birth (Arms, 1975; Kitzinger & Davis, 1978; Rothman, 1982). The notion that hospitals (the best location for implementation of obstetrical knowledge) provide the safest environment for childbirth may not be true (Mehl, Peterson, Whitt & Hawes, 1977; Stewart & Stewart, 1976). Countries, such as the Netherlands or Sweden, which employ midwives and which have a high percentage of home births, show lower infant mortality rates than countries like Canada where midwives are not recognized legally and home births are rare (Barrington, 1985, p. 124). Hoff & Schneiderman (1985) effectively show that the problem of safety has not been carefully researched and until that research is carried out there is no conclusive evidence from which to evaluate safety of hospital births in contrast to home births.

Iatrogenic disease, not recognized in indices of mortality, is according to Dr. Caldero Barcia, former head of the International Confederation of Gynaecology & Obstetrics, "the main cause of fetal distress" (quoted in Barrington, 1985, p. 122). Hospital births, with access to technological tools, are subject to hazards which are not always nor easily identified. In hospital there is a greater chance for a woman to encounter an episiotomy, the use of forceps, Cesarean section and other interventions raising the possibility of complications. The fetal monitor is a case in point. Baumgarten (1981) defended his position of recommending fetal monitoring for all women in labour by showing a relationship between increased use of fetal monitoring and lower mortality rates. The research by Haverkamp, Thompson, McFee, & Cetrulo (1976), however, did not support this recommendation. In fact Haverkamp et al. stated that routine monitoring is unnecessary or potentially harmful, citing the striking increase in Cesarean sections performed for fetal distress in the group of women attached to the fetal monitor (p. 316). While scientific research has not demonstrated any harmful effects from the use of ultrasound in childbirth, neither has there been conclusive support that show the certainty of its safety (ICEA, 1983). Barrington (1985, pp. 128-129) outlined the chain of interventive events that may begin with the innocuous routine adminstration of intravenous fluids but may lead to confinement to bed, drug administration to stimulate the uterus, forceps, lithotomy position, and episiotomy. Brackbill, Rice, & Young, of *Birth Trap* (1984) argued forcefully that there are risks with any technological intervention. It is also true that interventions in labour and delivery reflect cyclical changes in medical and social opinion rather than because of medical research (Wolkind & Zajicek, 1981, p. 126).

Childbirth management, on the part of both doctors and nurses, shows vividly the interests at stake (Rothman, 1982). "Management" means to direct or control, to make submissive to one's authority or discipline. Of course "management" is not necessarily a negative term. We use expressions such as "one manages one's own life." But in the scientific context of the management of childbirth the word "management" suggests that the experience is directed by doctors, nurses, or even machines (such as the fetal monitor in Christine's situation). Management as control is expressed in terms of mortality rates (control over death) and in terms of the initiation and control of stages of labour within predetermined time frames (control over women's bodies). Indeed, control can be a desirable quality but there is a need to question who controls who, how, and why.

Let us explore the medical and technical power over death we have come to accept. According to Oakley (1980), the prevention of death seen in perinatal and maternal mortality rates remains the chief yardstick by which obstetricians judge the value of their work. We have a situation, then, where "keeping people alive has become the primary medical goal and the quality of the lives thus extended has seemed a secondary consideration" (Oakley, p. 27). Illich (1976), Oakley (1980), and others have carefully analyzed the notion that decreasing mortality rates are directly attributable to the impact of medicine, or in this case, to obstetrical care. While there is a rise of modern professional and technological expertise at the same time as lowered mortality and morbidity rates, it is false to assume a cause/effect relationship. Possible contributing factors to the lowered mortality rates are higher maternal age and lower parity, improved nutrition, availability of effective contraceptives, changing abortion laws, decreased use of tobacco and alcohol by pregnant women, environmental improvement in water supplies, sewage disposal, and housing, as well as the choice women now have as to whether or not to have children at all. There is also the clash between the index of statistical survival and many mothers' own assessment of reproductive success. "Women evaluate the success of their childbirth in a more holistic way than the medical frame of reference allows," said Oakley (1980, p. 27).

The very fact that pregnancies are termed high or low risk already places women in a battle against death—a central issue. The continuum of risk, knowing there is always risk, is problematic. "Discovering that one is in a high-risk group increases the risk" (Benner, 1985, p. 13). Then, too, women who are initially defined as low risk may be moved along the continuum to high risk when treated with the measures that are needed by the high risk patient. Knowledge used to care for women who are ill or diseased during pregnancy and labour may be inappropriate to the well childbearing woman and introducing obstetrical knowledge into her care may move her along the path to becoming "at risk." "Each technical, chemical or surgical intervention carries its own risk," said Barrington (1985, p. 122). A simple example may clarify this notion. If a labouring woman is put to bed, and placed on her back because of the fetal monitor, she may need medication to control her pain which would otherwise be dealt with by her own movement—standing, rocking, or walking. The medication may lead to further interventions.

Most obstetrical "patients" are not ill and do not require medical treatment at all. The problem then becomes one of balancing the benefits and hazards to two different populations of mothers and babies, those who need medical care and those who do not (Oakley, 1980, p. 26). Because risk is a fact of life and one can never be sure, it is almost necessary, under the umbrella of obstetrical knowledge, for an obstetrician to say with authority that it is necessary to start an intravenous infusion on all patients "just in case" (Brackbill et al., 1984). This attitude is, of course, partly due to the increasing number of litigations. To "take a chance," when it means to take a chance with life, especially the life of a child, is not acceptable.

The problems of obstetrical knowledge become clearer when one begins to question its premise as truth. Scientific research, the foundation of obstetrical knowledge, which restricts the number of intervening variables so as to discover basic and functional relationships, is unimpeded by situational details (Franklin, 1984). Knowledge that separates itself from the everyday life of peoples' experience, therefore, needs care in its practical application. It can become easy to gear technology for use "as intended," (it is available, therefore it should be used) rather than be concerned about its use in the right situation. It is easy to see how women begin to feel like machines where, in a technological environment, they are attached to various pieces of equipment. For the woman, such an environment can be an alienating experience, which strips childbirth of meaning (Green, 1985).

There has been a response on the part of the obstetrical team to the grumbling voices of expectant mothers and fathers, and the childbirth advocates (some being the experts themselves). Efforts are being made to humanize obstetrical care through family-centered initiatives which include informing women of their choices, designing home-like birthing rooms, building free-standing birth centers, or implementing other programs, such as the Single Unit Delivery System, which provide opportunities for the women to labour, deliver, and to spend the post-partum period in the same room (McKay, 1982). In Alberta a nurse-midwifery study is presently being conducted which grew out of concerns of the possible dangers surrounding home births. In this study, called "Obstetricians and Nurse-Midwives—An Inquiry into a Team Approach," approximately one hundred women designated to be low-risk pregnancy candidates receive their pre-natal counselling, delivery, and post-partum care primarily from midwives. Another recent idea is for expectant parents to prepare a Birth Plan which lists their preferences of childbirth management which they discuss with their care givers and which they take with them to hospital at the time of labour (Simkin et al., 1984, pp. 12, 13).

The remarkable strides made in saving lives, especially of very ill babies and mothers, makes it difficult to question the appropriateness of a medical science approach. Even the humanizing procedures can seen as appeasing the concerns of childbearing women by "giving them what they want" while maintaining control of the birth process. Then again, one wonders if the knowledge and practice of childbirth should not be "human" in the first place.

Thus we see that while obstetrical knowledge has been useful in improving the physical safety of mothers and babies, there are problems with basing the childbirth experience exclusively on its scientific foundation. Concern has been expressed that obstetrical and technical knowledge, by seeing birth in such a narrow focus, puts into jeopardy the quality of human experience.

The Midwifery View

*Strengths.*One day, a few years ago, I stayed with a friend during her planned home birth attended by professional midwives who worked closely with a doctor in the city where I live. This is what I remember: Richard called me at six on that bright, clear May morning to say that Paula had been in labour since the early hours. Alice, the midwife, had been called, and Bill was coming to look after the children, Candace, age seven, and Paul, age five. Richard's mother was making breakfast when I arrived. I spent the day with Paula as she dealt with her frequent, painful contractions. Sometimes she sat on the living room floor supported by Richard, sometimes she walked to the bathroom, stopping frequently and leaning on us for support while the contraction passed, and sometimes she lay in the soothing water of a warm bath. Sometimes the house rang with laughter, and sometimes the quiet permeated the rooms to support her rest. As the "pains" became more intense, the tension of the family was evident. The children asked Bill to take them to the store. The grandmother stood in the bedroom doorway with concern showing on her face. The midwives made periodic checks and waited. Richard and I stayed close to Paula. I acknowledged her pain and her strength as she caught my eye as each contraction took hold. I knew she could do it and needed to remind her of that. Baby Joanna was born in the late afternoon, within the presence of her family and friends, and was immediately taken into the arms of her tired but relieved mother. The baby nursed for long periods at her mother's breast. In a short time Candace, Paul and Richard gave the baby her first bath. Later, we all gathered around the table for a feast to celebrate the birth, to celebrate the child, and to celebrate the mother.

Paula just could not think of having her third child in the hospital under the influence of obstetrical knowledge. What she feared was the sterile atmosphere, the attitude of doctors and nurses which she found debilitating, the separation from her other children and friends, the drugs and procedures, and her overwhelming fear of the pain. So while obstetrical knowledge strives to reduce or eliminate pain, Paula's fear of pain was enhanced by the application of obstetrical knowledge. She and Richard wanted this birth to be in their own hands as they had begun to question the shortcomings of the medical birth and its notion of safety. They had read the abundant material coming out of the childbirth movement, the women's movement, and the political movement which put into question the very roots of medicalized childbirth.

Paula did not have an episiotomy this time. From my nursing experience I was astounded to watch the delivery of the baby's head as it was guided so slowly (I thought) over the intact perineum by the hands of the midwife. All the births that I had seen were rapid by comparison as the baby's head was easily delivered through the incised perineal tissues. The benefits of episiotomies have not been well researched but the effects experienced by women are well documented. Pain (sometimes for many months), edema, and infection are the primary risks (Thacker & Banta, 1983; Barrington, 1985). There was pain for Paula, pain as strong as with her other two births, but she experienced it as more bearable this time being able to move around her own house with the support of those who loved her.

Midwifery knowledge has been practiced since the beginning of time. Even at the present time seventy-five percent of the world's population is born with the assistance of midwives within the home, the hospital, or the birth centre. Midwifery is recognized as a legitimate and necessary profession in most countries. "Of the two hundred and ten countries in the World Health Organization, only eight, including Canada, are without systematic provision for support by a midwife during normal birth" (NDP, 1983).

Midwifery knowledge takes two distinct forms, traditional or lay midwifery, and the "new," professional midwifery. In Canada, the move from the traditional midwife (also called lay healer, or wise woman) to the professional midwife occurred over the last hundred years (Barrington, 1985, p. 35). The decline of traditional midwifery knowledge and practice was due to the rise of a male-dominated medical profession (and its need for economic security), the push toward hospital birth where midwives were not welcome, and the emerging nursing profession which supported hospital maternity care (Barrington, 1985, pp. 25-32; Wertz & Wertz, 1979). Benoit (1984) contends that it was modern professional midwives who were the main medical actresses in the historical struggle to "scientize" and regulate midwifery practice in Canada, particularly in places like Newfoundland which has a long tradition of lay midwifery. The well-meaning actions of these male medical professionals and the professional midwives cannot, of course, be discounted.

The traditional midwife, still practicing in some parts of the world (Jordan, 1980) gains her knowledge through observation, personal experience, and through oral and craft traditions handed on from woman to woman, often from mother to daughter. The language of midwifery knowledge is the everyday vernacular and, therefore, available to everyone. Prerequisites of her role are experience, maturity, good character, and intense knowledge of the local culture and people (Benoit, 1984; Böhme, 1984). The midwife's task is to help the birth event take its own course, watching, waiting, and assisting the woman to bear the child—to bear what nature would bring. "Birth was nature in the sense of the Greek concept of *physis*: nature is what takes its own course, that which unfolds, reveals itself" (Böhme, p. 380). This knowledge respects the rhythm of women's bodies to bring the child to birth. As traditional midwives are women, their knowledge was self-knowledge, which is a subjective knowing of the experience of childbirth. Benoit (1984) suggested that the traditional midwife, the holder of lived-world knowledge (Chamberlain, 1981, calls it old wife's knowledge), and today's professional midwives, whose knowledge can be said to be the art and science of childbirth, are very distinct in actual practice. At least in industrial countries, traditional midwifery knowledge, knowledge of childbirth as a biographical and social event, has been lost, and with the loss of knowledge, the event itself has disappeared (Böhme, 1984).

I gave a rose to Paula to remind her to open herself to the birth of her baby. It just seemed sensible to do, and flowers are often given in love and friendship. In giving this flower I was not thinking that I was tapping into knowledge which is known and used in other cultures. Symbolic knowledge is as important or more important than physical knowledge in the majority of traditional societies (Bates & Turner, 1985, p. 30). Sexual imagery, stimulative imagery, and religious imagery operate according to symbolic meanings and association of the objects involved, rather than the actual physical attributes as perceived in an everyday sense (p. 30). The flower is the symbol of opening. Thus it is not the flower in itself that is important in this sense but it is the knowledge which understands the flower's symbolic "opening" that gives it its power. Old wife's tales, with their spells and remedies, for years discounted as unreliable, were not all harmful and may have contributed to useful traditional childbirth knowledge care by the women healers and midwives (Chamberlain, 1981).

Recently developed breathing techniques and methods (within the last 50 years) have been based on the separation of mind and body. Such techniques of concentration to discipline the mind (hypnosis and muscle relaxation) are used to divert attention from the body as a way of controlling the pain and act like drugs which numb the mind to sensations of the body. Control of the mind over the body can separate the woman from the sensation of her labour, its pain or pleasure, its struggle and power. Mind control separates women from "being there." In contrast to this mind-body separation, imagery, symbolism, and breathing in response to the body's rhythm accepts the integration of mind and body to assist the woman to give birth to the baby. Rather than using the breathing to control the pain the breathing helps to relax the body to feel the pains (contractions), to go with them, to open oneself to the rhythm and wisdom of one's own body.

The present practice of midwifery, seen in the professional midwife, and developed out of traditional midwifery, provides continuing care for the woman over the pregnancy, birth and early post-partum period. Professional midwifery focusses on the normal, that is, the healthy woman's experience of birth. In fact, these new midwives are specialists in uncomplicated childbirth. Their training, as distinct from medical and nursing training, provides comprehensive knowledge on all aspects of normal birth (physiological, social and emotional). Midwifery knowledge provides education about nutrition, labour and delivery, preparation for the actual birth, pregnancy surveillance (routine checks of weight, urinary glucose and protein, blood pressure, and other routine laboratory work), and post-partum care. Regular contact between the midwife and mother throughout pregnancy is focussed around diet, exercise, health habits, home life, and emotional concerns. The midwife meets the woman early in, or even prior to, pregnancy and continues the contact through to the post-partum period. This continuous support, essential during labour and delivery, develops over time by knowing the woman, her situation, and her wishes and, optimally, results in a relationship of mutual respect and trust. The trust established through this continuity of care is felt necessary for a healthy birth. The underlying focus of midwifery knowledge is, then, to support the birthing mother and newborn child and to create a situation where the mother, father and baby can share the first moments together. The midwives are in a sense "women helpers" rather than "doctor's assistants" as nurses have been seen (Jordan, 1980).

Only recently have midwives begun to work as midwives in some hospitals and in free standing birth centers, as well as in the home. Most often the midwives work as nurses on obstetrical units. However, not all of the new midwives are nurses and some feel that nursing education with its emphasis on disease is neither appropriate nor necessary for midwives. Like nursing, most professional midwives are usually female and that fact is felt, by some, as an important element in creating the understanding needed between the childbearing woman and her care givers. "The wisdom and compassion a woman can intuitively experience in childbirth can make her a source of healing and understanding for other women," said Gaskin (1977, p. 11), the self-trained midwife from The Farm. One thinks of the Greek Goddess of Childbearing, Artemis, who, although childless herself, decreed that only those who had given birth and were past child-bearing age could be midwives. The self-understanding that midwives have about their own birth-giving bodies may provide a thoughtfulness that an objective male view cannot bridge.

Problems. Yet, there are questions about midwifery knowledge. The acknowledged distinction between traditional or lay midwifery and professional midwifery makes one question if there is any substantial difference between professional midwifery knowledge and obstetrical knowledge. Is professional midwifery knowledge not just less expert and therefore second best? While it appears that midwifery knowledge is distinct, it may be that both it and obstetrical knowledge operate within the same framework, in a hierarchical relationship. What appears as an alternative, as in Paula's homebirth, giving the appearance of individual freedom and personal decision, may also be within the tightly controlled web of obstetrical knowledge (Benoit, 1984; Böhme, 1984). Medicine's influence has become so complex and all encompassing that many life events such as pre-pregnancy counselling for girls or menopause as disease are now part of medical practices and treatments (Donoff & Paton, 1984; MacPherson, 1981).

What if Joanna had died in childbirth? What if the midwives' knowledge could not handle the emergency that no one could predict? There is no emergency back-up for midwife attended home births other than sudden transfer to hospital. At the present time, with all the scientific, and technological advances, matters of safety, relief of debilitating pain, expediency, and efficiency cannot be ignored. Although statistics show that home births are safe for those women who are not ill and whose unborn babies are growing well, there is the problem of never knowing for sure whether complications at birth will develop. What about the unexpected maternal haemorrhage, for example? Although the midwife carries with her oxygen and drugs to treat haemorrhage, this may not be enough.

The medical profession stands strongly against midwife attended home births and even seems reluctant to give up their position and income (which has been called "economic territorialism", Barrington, 1985; Brackbill et al., 1984) to share their present role in the hospital environment. According to the British Columbia Medical Association, the creation of the profession of nurse-midwifery would be a "regressive measure." The reluctance to consider midwifery knowledge as different and essential for the childbearing woman keeps it in the realm of second best: useful only if the woman and child are risk free (which, of course, never really happens—there is always risk).

Another consideration is the fact "that risks of hospital births are socially acceptable and the risks at home are not," said Murray Enkin, Professor of Obstetrics and Gynecology, McMaster University (Reported in Barrington, 1985, p. 131). Rothman (1985) too, acknowledged that "it is the profession of medicine which has been granted professional autonomy, the right to make decisions, and thus the right to make mistakes in childbirth management" (p. 93). Our society tries to push away death to the extent that some individuals (especially infants and elderly) are forced to live without any chance for a reasonably acceptable quality of life (sometimes even for research purposes) (McDermott, 1985; Chinn, 1979). As a society we have accepted the medical view of childbirth management and can be critical of the practice of the alternative views.

Some have argued that it is selfish and morally wrong for women to be so preoccupied with their own needs that they take a chance with a midwife-attended birth. These people, including parents and specialists, say that, in the interests of the baby, it is not ethically right to take any chance if there is any risk to the baby (Hoff & Schneiderman, 1985). Some have even charged that having a home birth is potentially a form of child abuse (Barrington, 1985, p. 131). The massive increase in interventionist medical procedures that have been developed in the last forty years have been in the interest of the baby (Shorter, 1982). Fetal monitoring, episiotomy, Cesarean section, and even forceps ultimately are meant to serve the health of the new born baby. How could one not take all necessary precautions when a newborn is involved? If, however, midwifery knowledge is distinct and valuable for the childbearing woman, why should not the "high risk" woman also be given the right to the midwife's care. Relegating midwifery knowledge to "alternative" status limits the possibility of making it available to all women, those with no apparent problems as well as those designated high risk. This concern forces examination of the very foundations of obstetrical and midwifery knowledge.

There are those who feel that midwifery knowledge is good because it is a way of reducing the spiralling cost of health care. It has been demonstrated that midwifery care, especially in the home setting or in a free standing birth centre is more economical than the technologically-equipped hospital birth (Brackbill et al, 1984; Barrington, 1985, NDP Position Paper, 1983). Of course, it is necessary to contain and reduce the costs of health care, but the cost factor as a reason for the implementation of midwifery knowledge is problematic. There is the danger of people being treated differentially according to economic circumstances. The reason for using a particular form of knowledge needs to be assessed from the point of what is appropriate for good health and not from the ability to pay.

The Methodological View

Strengths. In the 1930s Grantly Dick-Read initiated the "how-to" movement in preparation for childbirth. Dick-Read, and his followers, Lamaze in the 1950s, Bradley and Leboyer in the seventies, and Odent in the eighties are medical doctors who developed techniques to reduce or remove pain for women (Lamaze & Bradley), reduce the trauma to the infant (Leboyer), and tap into the natural (primal) abilities of women (Odent). Dick-Read explored the relationship between tension and pain and applied it to childbirth. Women were encouraged to relax so that they could break the vicious circle of tension—pain—more tension—more pain. Lamaze based his work in psychoprophylaxis (or mind preparation) on Pavlov's theory of conditioned-response which called for women to learn to respond to the uterine contraction by active relaxation of muscular tension and to initiate a particular breathing pattern. Very specific in methodology, the Lamaze method teaches the woman to control her own childbirth experience not just by passive relaxation but by active decontraction in a very deliberate effort to have her mind control her body and to pattern her breathing to recognizable stages of labour. Bradley's fame centered around his concern for the active role of the father in controlled childbirth. The Bradley method, using a breathing pattern different than Lamaze, calls for the husband to act as coach throughout pregnancy and labour within the obstetrical milieu.

The increased interest in the well-being of the fetus and newborn is behind the work of Leboyer who described birth as a traumatic event for the baby. His efforts were directed to providing an environment conducive to welcoming the newborn into the world in a gentle soothing way by dimming the delivery room lights, decreasing unnecessary noise, emersing the newborn in a warm bath, and giving gentle and stimulating massage to the baby. Leboyer claimed that by reducing the trauma to the newborn, the child would grow up happier, more intelligent, and physically stronger.

Odent, a strong critic of medicalized childbirth, has turned full circle and suggested that women themselves should be the directresses of birthing. Odent is a male and a surgeon yet he is striving to show that women, primordially, know how to deliver their own babies and has been instrumental in creating a hospital environment which supports this innate ability. While revolutionary in nature, with no use of forceps, few episiotomies, a low Cesarean section rate, and no pain relieving drugs, Odent's approach has caught the attention of childbearing women and childbirth activists but has done little to turn around every day practices in most Western hospitals.

There is more to the childbirth reform movement than these famous medical men. Women have taken the lead in childbirth education for many years. Their energies have often been triggered by personal experience in childbirth recognizing the need to share with other women their realization that childbirth is an experience to be enjoyed and treasured as active participants. Gaskin (1977), Kitzinger (1979b), Peterson (1981), Simkin et al. (1984) and Panuthos (1984) have developed, broadened, and surpassed the "guru" methodologies in an effort to educate women and men for childbirth.

Edwards and Waldorf (1984) exposed and clarified the male domination of childbirth. They said, "Even in the women's world of birthing babies we see innovation and reform dominated by the names of male obstetricians, while methods originated or developed by nurses, physical therapists, or midwives if they survive at all, are known by the name of whichever medical man made them famous" (p. vii). In their book, *Reclaiming Birth*, the authors described childbirth heroines such as Margaret Gamper, Elisabeth Bing, Lester Hazell, Niles Newton, Doris Haire, Sheila Kitzinger, and Raven Lang who have struggled "to dignify the ordinary experience of women as they become mothers, thus contributing to the salvation of life's essential human quality" (p. xi), but who are not as readily recognized as the famous males. It would be of interest to explore the number of males in the obstetrical field who would agree with Odent's (1984) statement that it is "time when male obstetricians would do well to retire progressively and restore childbirth to women" (p. 118).

Many women have directed their efforts in returning the childbirth experience to women through techniques of mind-body integration (Peterson, 1981; Panuthos, 1984) or tapping into spiritual energies (Gaskin, 1977; Lang, 1985). Kitzinger, an internationally known childbirth educator and activist, was one of the first to question techniques which advocated distraction as a means of coping with labour pains. These techniques turn women away from the happening in their own bodies. Although many women use distraction to raise their pain threshold, Kitzinger (1978) encouraged full body awareness (both sensual and sexual) in order to feel the "intense and thrilling sensations" as the vagina opens to birth the baby.

Childbirth education classes sprang up to deliver these promises of a "good birth." Because of the fear of the unknowns of birth, attempts have been made to structure the experience with many methods. The International Childbirth Education Association and the American Society for Psychoprophylaxis in Obstetrics are two groups that have developed and extended methodological approaches. As well, they are advocates for change in childbirth practices. Over the years there has been increasing recognition that there are strong links between the women's health movement and childbirth organizations. "Both groups attempt to change existing health services; both create alternatives to provide care consistent with their ideals and both use the process of consciousness raising to increase self-esteem and confidence" (Edwards & Waldorf, 1984, pp. 193, 194).

Problems. Yet, while there is value in these techniques which have helped many women to prepare for and experience a wonderful and satisfying birth experience, there are problems, too. There is danger of a dogmatism in supposing that there is a "right" way to birth. Although a particular method gives tools for women to use to control their own experience they sometimes do not work in spite of careful preparation. Those women who lose their own sense of control and experience pain, forceps, drugs, Cesarean birth, or long and difficult labours often feel guilty that they have not managed well, or angry that they have not been well prepared. They are left feeling unsure of themselves and their abilities. In a sense, some of the tools of childbirth preparation, such as the breathing patterns and relaxation techniques, come to be used in a technological way, almost like machines. Kitzinger recently described the Lamaze method as "an athletic, goal-oriented blueprint" which basically accepts the male domination of birth (Odent, 1984, p. xviii).

"If we are to be entirely truthful," said Elizabeth Noble (1984), a childbirth educator, "we have to agree that birth is a journey into the unknown, and every couple has to wing it with courage and insight" (quoted in CBC Transcripts, p. 19). Even words like "positive," "assertive," and "normal," convey the idea that there is a way to give birth that experts know about. Women, therefore, are faced with their own experience plus a formula which has been set by people who obviously know more than they do. Even if experts have general knowledge about birth, they know very little about a particular birth. Each woman must birth in her own style and uniqueness with support from those who can help her in whichever way is best for her (which may include medications and medical intervention).

There is a problem, too, of who controls the educational programs and pays the childbirth educator. Some childbirth educators work within the hospital setting where their allegiance is to a particular hospital and the practices therein. Others feel that the educator should show allegiance solely to her students, and that no institution or doctor should have control over the course content either directly or indirectly (Goer & Euzent, 1984, p. 109). The childbirth educator's dilemma is even more difficult in accepting the need for preparing women for the reality of obstetrical childbirth at the same time as helping her to see beyond its limitations to recognize her own abilities to give birth as she wishes. The individual woman's childbirth experience should never become the battleground where forms of knowledge are being questioned (Jiménez, 1984).

The pragmatic attitude of the various methodologies is especially effective for women who have the economic, intellectual and social opportunities to take part in childbirth educational programs and to make educated choices about their individual situations. What happens to those who do not have these advantages? Of even more concern is the fact that in the very opportunity of choice there is the possibility that one loses what is of real value. Is what happens in childbirth just a matter of individual choice, with the idea that "what is good for me may not be good for you?" One childbirth educator said, "It is not my goal for all my students to define a safe, satisfying birth experience in the same way I do" (Shearer, 1984, p. 175). Does this mean it is all relative? Should it be a matter for each mother to take responsibility for her own birth, for her own health and the health of her baby? This notion deposits the responsibility of the "good" into the hands of each individual who is situated in a world of diverse forms of knowledge and opinion, in a world of the best salesperson, the best educator, the world of the powerful opinion.

The Critical View

Strengths. An obstetrician's comment to a father's request to have other children attend a hospital birth was, "why would you want to have your children see a dirty thing like that?"[2] It is casual remarks like this that demonstrate the need to look at the deep rooted factors from which such remarks spring. According to Harrison (1982), a doctor herself, many women have experienced the brunt of doctors' attitudes in silence. This silence is being broken through the eloquence and clarity of feminist scholars (O'Brien, 1981; Oakley, 1980, 1984; Rich, 1976; Kitzinger, 1962, 1979b, 1983; Morgan, 1984).

O'Brien (1981), in stating that human reproduction is inseparable from human consciousness, claims that there can be no analysis from the standpoint of existing theory because the theories themselves are products of male-stream thought (p. 23). What is needed is to "turn to the fundamental process in which the reproductive relations are grounded and subject it to analysis from a female perspective . . . and from a method of inquiry from which such theory can emerge" (p. 24). The fact that women now have a choice of mothering, that reproduction can be voluntary rather than involuntary, makes it necessary to search for greater understanding of how the process of reproduction influences women's understanding of themselves. It is possible, according to O'Brien, that male reproductive consciousness (alienation through the separation of man from nature and from continuous time) is the basis for the dualistic preoccupation of male philosophy which sees a separation between mind and body, subject and object, past and present, and even, perhaps, male and female (p. 34). She said, "Men have brought to obstetrics the sense of their own alienated parental experience of reproduction and translated it into forms of an objective science" (p. 46). Women mediate their alienation through the act of labour while men appropriate their alienation through objectification and control (p. 32).

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[2] Seminar on Family-Centered Perinatal Care, University of Alberta, February, 1983.

The struggle of critical childbirth knowledge from a feminist perspective strives to uncover the female reproductive consciousness. The male-dominated culture has not given a high value to the creative power of reproductive labour and the act of giving birth (O'Brien, 1981, p. 149). The mediative value of labour itself should be brought under scrutiny. The fact that children are born from the labour of women is often ignored, their labour has become something that needs to be "gotten through" in the fastest and easiest way possible. The rapid rise in the Cesarean section rate has not been questioned from the point of view that women's active participation in the birth of the child is itself important to the development of the female reproductive consciousness. O'Brien states that women's labour confirms two important issues. "One, obviously, is the knowledge of this child in a concrete sense as *her* child, the product of her labour, a value that her labour has created. The second is the experience of an integration with the actual continuity of her species" (1981, p. 151). Paternity, on the other hand, "is essentially an idea—fundamentally abstract, passive," and this problem of the uncertainty of paternity has resulted in the universal oppression of women (1981, p. 152). The value of labour needs to be reconsidered from the view that it is important for women's own self-understanding, and as an important contribution to society as well.

O'Brien (1981) and Rothman (1982, 1983) argued that there needs to be a reassessment of the linear view which describes the stages of labour in a rather mechanistic progressive way. The fragmented, unilinear view propagated by obstetrical knowledge and its carriers (the doctor, the hospital, and even prenatal information classes), sweep women into a chronology of pregnancy and childbirth that dissects the experience into logically apprehended, definable, and recognizable events, such as the 40-week pregnancy, or the 12-hour labour. Women now talk of "being late."

Lateness becomes a concern only when it is contrasted to "being on time," meaning giving birth on the right date. The due date appears to be so important that pregnant women are frequently exposed to ultrasound examination in order to pinpoint the exact date. Of course, there are considerations which support the desire to know the expected date; that the baby is growing adequately or so plans can be made accordingly. But the words "lateness" and "due date" indicate a view that nature should be punctual, that it should know the Gregorian calendar. Without modern obstetrics, women would be less concerned with "lateness." The use of "moments" or cyclical time is more in touch with a woman's natural experience of time, her biological relation to human reproduction. The male experience of discontinuous time (O'Brien, 1981, p. 32) may have precipitated the notion of "time as enemy" to be dominated, controlled, and abstracted. Of course, this is a broad problem related to a concern that with technological control we become less sensitive to the extent to which other things have their own time as well.

Susan Griffin's books *Women and Nature* (1978) and *Pornography and Silence* (1981) touch women's realization of their oneness with nature. The objective view of women's bodies, whether finding them "dirty" or "beautiful," or as "machines" to be dominated and managed is a function of the pornographic mind (Griffin, 1981). Griffin makes it clear that women's relationship to nature through her body is a powerful force for integration—integration in body and soul, in mind and emotion—and separation of womb from body as in medical childbirth is cause for the feeling of self-alienation or disintegration. In a society which demands objectivity, which separates nature from culture, which separates body knowledge from language, which sees nature as something to be controlled, there is danger of losing the self.

> Consciousness and meaning are part of nature. . . . When bodily knowledge and language are separated, we ourselves experience a terrible separation which ranges all the way from grief to despair to madness. . . . In this way culture destroys a woman's conscious knowledge of her own experience. Just as she is separated from other women, and from her body and her feelings, she is, finally, a stranger to herself. (Griffin, 1981, pp. 228, 247)

It is little wonder that women have been willing to accept the domination of scientific obstetrics as, over time, they have been separated and alienated from their own experience. Griffin and others have inspired women to recognize (from Latin *recognōscere*, "to know again") their unity, their oneness with nature and their bodies. In coming to this awareness women have begun to believe their own strengths to give birth to their own children and are taking back that right.

The impact of technology on childbirth is all-encompassing and pervasive. Franklin (1984) is concerned that women take an active part in changing or developing technology that is fashioned into "a web of life that is intrinsically human." In so doing there may be a way to use technology in a human way rather than to "humanize" it with cosmetic overlays. The values and attitudes of the technological world vary substantially from values of the woman's world. Technology's emphasis on narrow specialization that allows interchange between people and devices, complex hierarchical structures that demand careful planning and scheduling, efficiency and productivity that necessitates the doing of something that is measurable, clash with women's world values. Women, according to Franklin, tend to value flexibility and unpredictability, non-specificity and integration, horizontal structuring with irreplaceable and diverse skills, inventiveness and spontaneity, with emphasis on the ability to cope with a variety of circumstances rather than productivity. Franklin recommended that effort must be made to integrate the values of women's world within the technological order. Women cannot turn away from technology but need to understand its nature (in the struggle for clarity) and to strengthen the bond among women to protect their values (in the struggle for community).

Philosophers (Heidegger, 1977a, 1977b; Idhe, 1979, 1983; Burch, 1984) suggested that deeper questions need to be asked about the way we live as humans in an environment of technological rationality. In order to question technology one has to step out of the technological frame of reference to explore our relations with machines. Technology is neither neutral nor a mere tool which helps to get the job done. Technology opens up ways of doing things not otherwise possible. The fact that technology opens up or amplifies possibilities means that it also closes down or reduces other possibilities. Burch (1984) said that through philosophical reflection we must make an effort to "make ourselves aware of the ways in which technology . . . transforms our experience, [and] limits our perception and understanding," to free us from "the essentially non-technological hold that technology has had upon us." This would make us "free to open ourselves to the fuller range of human possibilities within a relation to technology, possibilities then for putting technology in its place" (pp. 14, 15).

Illich, an outspoken critic of modern medicine (1976) and professionalization (1981), said that the existence of "hospitals that spew out the newborn and reabsorb the dying" is a vicious attempt by professionals to replace the nests and snake pits of culture by the sterile wards of professional service (1981, p. 20). The move to professionalization and its limiting of specialized knowledge to the experts creates needs which then need to be met through marketplace practices. The need for expert knowledge and care (the sterile wards) has replaced the common sense knowledge, which in our case is the ability of women to birth their own children within a community (nests and snake pits). There is, of course, value in reducing the trauma of "snake pits" while keeping open the protective "nests" of culture.

The marketplace model of childbirth turns childbearing women into consumers or customers, and doctors and other professionals into entrepreneurs or business people. Such a relationship changes care into profit, informed consent into sales contracts, and sees medical research and practice a thriving business. The business of health care, whose profits make up ten percent of the gross national product in the United States, includes the medical professionals, the manufacturers of costly machinery, the drug companies, the insurance companies, and the government (Edwards & Waldorf, 1984, p. 191). It has also been found that "obstetrician-owned antepartum fetal monitoring equipment is often 'marketed' to pregnant women during prenatal office visits despite four randomized trials which failed to show benefit from these procedures" (Shearer, 1984, p. 213). Those who see the market model as important say that the managerial process could result in a carefully formulated program that would allow the doctor to practice medicine and serve the community more effectively and efficiently (Chez, 1984). The marketplace model of childbirth becomes one in which the woman is subject to the rationalization of efficiency, expediency, and safety as criteria from which to judge the procedures. Does this not leave the woman at the mercy of the best salesperson?

Problems. Yet it is possible that these critiques are highly idealistic and removed from the lives of people. Writers like Illich who recommend a return to subsistence living do so with the help of high tech media, communications, and transportation. Are the critics, perhaps, so captivated by their own messages that they fail to see what is right and good in individual circumstances, such as how a woman acts in a world dominated by a powerful form of knowledge that rationalizes itself? Do not these critics of professionalized, sexist, technological, and marketplace childbirth leave women angry and confused, yet impotent to do anything about their individual situations? Does it not result in antagonism, mistrust, refusal to cooperate, and revolutionary activities which would not have occurred if these scholars didn't "stir things up." There is a need to get beyond words and ideas. One of the needleworkers on Chicago's *Birth Project* said, "We need the vision-seekers and radicals to confront the status quo and imagine new worlds, but it is women like us who can step between the worlds to make feminism more than words and ideas" (Biondo, in Chicago, 1985, p. 105)

It is often suggested that a female doctor, or the increasing number of female doctors in obstetrics, is a turn for the better. This is not necessarily the case. It is understandable that women who have been immersed in the medical approach to childbirth, often working harder than their male counterparts, are not easily critical of their new milieu. Like immigrants, they may tend to seek conformity in language and habit, absorbing the new culture and even defending its system (Franklin, 1985). This conformity frequently necessitates compromising their own female experience and results in the breaking of ties with their natural community. Women who do try to maintain these ties with the truth of their own roots often leave their medical practices, or find their place in alternative approaches because personal discrepancies and concessions are too great (Harrison, 1982).

Is it not dangerous to suggest, as O'Brien has done, the need to see reproductive labour as valuable or necessary? Would not such an idea support the beliefs by some religious sects and philosophies that women should expect to suffer pain in childbirth? Even Griffin's emphasis on women's ties with nature could be used against women. A return to nature, in any romantic way, would leave women more vulnerable and at the mercy of nature's inequities and catastrophes. Women also are part of the culture that looks at pain as unnecessary and to be avoided and most would want it to remain that way. We do live in a technological world which provides opportunities for control in the most efficient and effective way. While we do not want to deny the value of the instrumental power of technology, we must take care not to be caught in the hegemony of instrumental reasoning.

The Relationship of Knowledge and Self-understanding

From the above analysis it may appear that forms of knowledge are tied to a particular professional. It may seem, for example, that the doctor, the obstetrician, and the nurse are representative of medical and technological knowledge, midwives of midwifery knowledge, birth educators and advocates of methods, and the scholars, and/or feminists, of the critical view. Of course, things are not that simplistic. The doctor may use midwifery knowledge from a feminist view. The midwife may be practicing in a hospital that is geared to the pathological situation and be the proponent of obstetrical knowledge. The birth educator may resist marketplace practices and be only interested in preparing individuals for their particular experience with little thought of money. Similarily, the scholar may never have been close to an actual birth, or may, conversely, *be* a nurse, educator, or obstetrician.

If the application of knowledge is related to self-understanding is there a form of knowledge that can be applied in all situations? Or is there, as has been suggested, one form of knowledge that is appropriate for the high-risk woman, and another for the low-risk woman? Is it only sometimes appropriate, depending on the individual choice, that care is taken so that the environment into which the new baby arrives is one of gentleness, concerned with human touch, concerned with the touch of the family? Is it appropriate for only some women to have access to the fetal monitor or to have a care giver who offers continual support and understanding? Is it appropriate only for women who question the need for drugs and episiotomies to be given the support and time to avoid both?

Meno asked Socrates, the midwife of knowledge, whether virtue is acquired by teaching or by practice or by another way (Sesonske & Fleming, 1965). Socrates circumvents Meno's question by asking another question, the question of virtue itself. How often do health professionals, like Meno, get caught in the question of "how" rather than searching to a deeper meaning of "what" it means to a woman to birth a child? In the childbirth situation nurses, midwives, childbirth educators, yes, even doctors, stand close to the woman in her act of giving birth.[3] Their knowledge, attitude, and care can make the difference by assisting, or opposing women as they come to understand themselves as childbearing women and mothers.

In 1974 when I was pregnant with my second child I decided that I wanted my new baby to stay with me from the moment of birth. Hospital practice, at that time, separated mothers and babies for a 12-hour observation period. During those hours the baby was kept swaddled in a blanket and placed under a warm light in a clear plastic bassinet. It was in 1972 that Klaus and Kennell published their first research which suggested that "extended neonate contact makes a better mother" and demonstrated the importance of the first post-partum hours and days for the development of maternal attachment. Unfortunately for me, their research had not yet reached northern Canada. I knew that it would be necessary for me to have "scientific" research to support my request so I armed myself with this latest research and anything else I could glean from libraries to prepare myself to face my obstetrician and the head nurse of the maternity ward. Although both reminded me of how tired I would be, and that new babies need constant care, with one even declaring that babies "like" to be in the nursery, it was agreed that—given a healthy child and an uncomplicated birth—my baby could stay by my side. My daughter was born late one Saturday afternoon into the hands of the doctor who arrived just in time to put on sterile gloves and who left two or three minutes later. The head nurse did not work on weekends, and the agreement posted on the bulletin board in the nursing station was not sufficiently powerful to change routine. So I was left standing outside the nursery window looking at my new child.

I have provided the above illustration in order to expose a number of points. First, childbirth practices change over time depending on the current research available or depending on who is in charge (Green, 1985). Now, in 1986, mothers and fathers are encouraged to stay with their child for at least one hour or more after delivery (Klaus and Kennell, 1983, Young, 1978). If women are too exhausted or otherwise not able to attend their child at this time, this observation is noted on the chart as an incident of concern to staff. Secondly, scientific knowledge or opinion is more powerful than personal knowledge or opinion. There is a beginning realization that the "scientific" model of research used in the natural sciences, is not the only appropriate form of research necessary to understand the human situation and health care specifically (Buytendijk, 1974; Polanyi, 1969; Pelletier, 1979; Bergsma & Thomasma, 1982; Cousins, 1983). Research that attempts to understand the way experiences are lived by humans is now being introduced in many fields of human science research. The third point is to remind us that routine practices are often carried out for their own sake. It has been identified earlier in this paper that routines such as perineal shaving, enema, and episiotomies are often practiced routinely without the support of scientific research findings or consideration of individual wishes. There needs to be constant re-evaluation of routines that become engraved into practice (Stewart & Stewart, 1976). The last and most important point for the current discussion is that applied knowledge effects women's understanding of themselves.

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[3] The word obstetrics comes from the Latin *obstetrīx* meaning "midwife," but apparently this term derives from the verb *obstāre* which means literally to "stand at, before, or against"—usually with the sense "to oppose, hinder."

Again let's look back at my experience: I was excited about the birth of another child, and a girl, too. Now we had a boy and a girl. The labour was intense, and at times overwhelming which I handled with the support of my husband and nursing staff. I felt good. Our separation was a disappointment but I began to think, "They were right after all. The routine was there for a purpose. Perhaps I couldn't handle the situation if she choked and turned blue. What if something did happen to her if she were left in my care? Could something happen to her?" The self doubts that gradually seeped into my thoughts encouraged me to stand back from what I had previously known as right and good—which would support the bond between myself and my child—to let the experts do what in their opinion was right and good.

As I think more distantly about that woman at the nursery window, and the baby in the bassinet, I wonder if there is even more at stake here than originally thought. What makes a woman a mother? Does it have to do with watching, holding, nursing, suctioning, and diapering? Yes, of course, it is all those things. But is it not more, also? But what? How did that mother know something the scientists did not yet know? How was her understanding of herself as a mother different than theirs? How do the forms of knowledge used in childbirth contribute to that understanding of woman as mother?

It is not necessarily true that one way of approaching birth is more "natural" than another. For many years midwifery knowledge was used exclusively for childbirth. It was the natural way. Now obstetrical knowledge has taken its place. It is now common place. Many breathing patterns taught by various methodologies are not natural, and it not natural to think that labour and its pain has any value for women. It is important to question how the different constructs (knowledge forms) either empower women, or decrease their power to structure childbearing around their own needs and those with whom we live (Hubbard, 1984, p. 332). Each approach to knowledge offers the woman a way to come to grips with her own situation. The way a woman approaches childbirth, that is, which forms of knowledge she encounters, has an effect on how she comes to understand herself. What could a woman, Our Woman, learn about herself through her encounter with the application of various forms of childbirth knowledge? In the course of every day living the idea of "knowledge forms" does not mean much. Our Woman who is pregnant may have all kinds of questions, understandings, uncertainties, and doubts.

But what you do with such questions when you make a routine prenatal office visit? Entering the office to a room full of sick or well people, Our Woman gives her name to the receptionist who retrieves her patient chart. During the initial waiting she stands on the scale, has her blood pressure taken, her urine analyzed, plus any other tests, which are then recorded in clinical numbers on the chart that the nurse retains. After what sometimes seems like an endless wait, Our Woman is escorted to an inner clinical room for another indefinite time. Her chart is put on the outside of the door. This wait gives her time to recall what she may have wanted to ask the doctor once he/she gets there. She reads the doctor's certificates on the wall. Our Woman may investigate the calender that has interesting drug information, or if she is prepared, she may read the book or magazine that she has brought for this purpose. The nurse comes in. She may be asked to remove some of her clothes, perhaps from the waist down, and cover herself with the sheet or gown. Most often when the doctor does come in, he/she will read the chart and do whatever further examinations that are necessary. There is a moment or two for questions. But Our Woman no longer has any questions. The ones she had are no longer important. After all, the doctor is a busy person with all those others waiting their turn. Anyway, it doesn't matter, because everything seems to be okay. She has passed the inspection for another week or two. Perhaps she will remember her concerns the next time.

Who is this woman? She may be comforted by the authority and protection of obstetrical knowledge when experienced throughout her pregnancy and birth. The authority of obstetrical expertise makes it easy for her to say, "Whatever will be will be!" "There is not much I can do about it!" and be grateful for the technology and expertise which give good chances for the birth of a healthy child. She may expect to be looked after, and although she may balk at the patriarchal manner of some doctors who say, "Don't you worry about a thing, my dear, we will look after you," she is trusting of the power of knowledge that makes it possible for anyone to say that. She may see herself as powerless in this situation where independence and self-affirmation are withheld from her. After all, "they" know best. She may even go back to what she may describe as a negative situation a second time. "It is the devil I know," she says, "At least I know what to expect."

Our Woman's encounter with midwifery knowledge may go something like this. In her visit to the clinic, Our Woman is encouraged to weigh herself, to check her own urine, and to record these measures on her own chart which she carries with her. She waits her turn in an waiting room filled with other pregnant women and babies for this is the day set aside for women and babies. Over the weeks she develops friendliness with others like herself. The midwife or doctor discusses any of the questions and concerns that Our Woman has in an of atmosphere mutual sharing. Perhaps, they talk about who will be attending the birth to look after the other children, or they will go over the diet record that Our Woman has maintained for a week. If she already has children, they may be included in the visit, perhaps even for the physical examination. The midwife also visits the home to discuss preparations for the birth—the supplies needed, suggestions for who and when to call. Questions that Our Woman may not have brought to the clinic may be discussed more easily in this home setting.

Our Woman, to have access and to choose this alternative approach, has to know that it is available. She is probably like the woman who said, "I've read a lot about childbirth, and I searched for a place where I could birth my child the way I want. I'm not one to like a lot of intervention in my life." By her very questioning, Our Woman stands against the status quo, the currently accepted practice. She stands determined to make decisions for herself in consultation with those she chooses as childbirth attendants. So for women to request the use of birthing rooms, birth centre or home birth, limited intervention, and so on, they must first have the information about the alternative and then must negotiate these privileges which are meted out for the right weight gain, the right laboratory tests, the right dilatation, the right progression and timing, or the right parity. Those women who are not aware of the alternatives or deviate from these "right" attributes automatically receive the benefits and the risks of obstetrical knowledge without question.

The "how-to" methods have offered Our Woman a sense of control of her own situation which she may find helpful and personally strengthening. A particular method will give her something to do, a way to act. But if control is lost, for whatever reason—situational, physical, or emotional—Our Woman senses regret and loss. Loss of control may mean loss of confidence, feelings of guilt, and defeat. The need to control puts Our Woman in an adversarial position of standing up for her rights, being firm, arming herself with her Birth Plan and the latest scientific facts to allow her to maintain that control.

What about the self-understanding of Our Woman, the feminist, or Our Woman, who is influenced by technological, professional, and marketplace critiques? She may see herself questioning the domination of certain points of view and see herself fighting for something deeper than her own particular situation. She may feel angry and negative about what she sees as restrictive, oppressive practices while being convinced that childbirth is a time in which she should be able to express herself in a highly intense and personal way. Here Our Woman is left to struggle to find her own way in a world that may not even understand or appreciate her very female nature. She may describe herself as rebellious, as one woman who said, "It's us against the world."

Yet how does Our Woman find a physician who is able to work with the nature of women, who does not see women's bodies as machines to be manipulated and controlled in the most efficient way possible? How does she find someone who will not accelerate or slow down her contractions to fit into a linear understanding of labour or the marketplace timetable? How does she find a physician who is not threatened by her demands for equal participation in the decisions surrounding her baby's birth? When or if she does find a doctor who suits her needs, how can she be sure that she will not be transferred to an unknown colleague when nature starts the course of labour in its own time? For many women the support from childbirth groups, such as Safe Alternatives in Childbirth, International Childbirth Education Association, or the La Leche League, is invaluable. Others choose the support of smaller less organized groups where they, in an atmosphere of trust and friendship, come together with other women to discuss issues central to women's health.

At the present time obstetrical knowledge is so firmly grounded as the appropriate approach that the other forms identified here are the "alternatives." So it is against this environment that women come to deal with themselves and their own situation. They may accept and go with the status quo. They may be subversive and plan a home birth with whatever support is available, for example with midwives in attendance. They may become advocates for better care within the system, like those who make efforts to humanize existing practices. They may become mobile within and use everything to their own advantage. They may be like gadflies and try to deflate the current hegemony.

It is Our Woman herself who bears the child that is created hopefully in the act of love within an intimate relationship. Certainly, it is recognized that many women carry and bear children alone, that is, without the support or interest of their partner in the act of conception. Certainly too, many men are actively involved in the coming of the child, so much so, that they can talk of their own internal experience of becoming a father. But, because of women's corporeality, childbearing remains her responsibility and opportunity. In recognizing that giving birth is a personal process for women we come to see that the birth of the baby is the woman's birth, that is, her birth into motherhood, in close relationship with the child's father. Yet, even the father's view of the birth is externally mediated, and is, in some sense, like that of the doctor, the nurse, the birth educator, and even the courts. For Our Woman to birth a child is indeed to birth herself as a mother, and from those moments to live in the world as a mother. It then becomes a matter of recognizing that the application of childbirth knowledge is a way for women to understand themselves.

Our Woman has a choice. In fact, the matter of informed choice is a current obstetrical concern. To make an informed choice means that Our Woman needs to be shown all sides of the picture, the benefits and risks of each option. These opinions may, however, be so entrenched in the particular form of knowledge that there is danger that opinion, itself, is understood as the truth. What is more problematic is that Our Woman may have lost the realization that there is any real choice at all, when for most of her life she has deferred to the experts for basic decisions. Or she may have been trapped by inexorable circumstances where there are few choices. Or, in fact, Our Woman may not even see herself as a person who can choose.

The Research Question

The analysis of forms of knowledge (obstetrical, midwifery, methodological and critical) shows the dilemma for the childbearing woman. The effort to assist women to make knowledgeable decisions from this menu of possible choices has been an important endeavour of childbirth educators, and childbirth education associations. The first concern is the health of the mother and baby, and, secondly, the emotional fulfillment of the mother, father, and family. It is recognized that for most people, "becoming parents [mothers] is a greater life change than any other they will experience" (Simkin et al., 1984, p. 3) and the literature available gives information that influences their changing form of life, but it inevitably stops there. Investigation of the experience of change, itself, is not included. Each of the forms of knowledge explored above must be recognized as influencing women's understanding of themselves as they move to become mothers.

The question for a woman is not only "what approach to childbirth knowledge shall I use in my own personal preparation for childbirth?" but is rather, "how does the knowledge I use in childbirth contribute to how I come to understand myself as I move to motherhood?" How does a woman "live" childbirth knowledge? It is from this place (ground, horizon) that the question of this dissertation becomes intelligible. The primary question is, therefore, "How does a woman come to understand herself as mother?" How does the experience of childbirth transform woman to mother? *What is the nature of the transformation of woman to mother*?

Chapter 2

A WAY TO UNDERSTANDING WOMEN'S EXPERIENCE

The Nature of the Question

Chapter one endeavored to lay the ground from which the pressing question of this dissertation would show itself. Four approaches to childbirth knowledge—obstetrical, midwifery, methodological and critical—were explored in such a way as to show the relationship of childbirth knowledge to the self-understanding of women. Our Woman was created as an example to clarify the need to question further the experience of the childbearing woman in the situation of competing forms of knowledge. The question addressed by this situation is then, how does the experience of childbirth transform a woman to mother? That is, what is the nature of transformation of a woman to mother? In a question about understanding a woman becoming a mother there can be no separation of the knowledge of the events from the meaning of the events. "Meaning resides not solely in the individual nor solely in the situation but is a transaction between the two so that the individual both constitutes and is constituted by the situations" (Benner, 1985, p. 7). The question of becoming a mother is one of meaning—what does it mean to be a mother? How could we approach a question of meaning?

It may be possible, one could suppose, to create a list of validated possible changes that occur in a woman's move to motherhood in order to explore how many are experienced by women in various socio-cultural or demographic categories. By doing so, one may then be able to compare the older first time mother with the younger, or differences related to education, economic circumstances, social class, social status, and so forth. Or one could send out a questionnaire before and after birth, and compare the results with a control group of women not yet mothers. But do such approaches get at meaning? With questions of meaning it is the context, the story, the preunderstanding, which cannot be made fully explicit, nor completely clear and which opens one to possibilities and to conditions for perceptions and action (Benner, 1985). Acknowledgment that human beings, with language and culture, are different than objects makes reductionist research less valuable, and indeed, ineffectual in questions of this nature.

Method can only be arrived at dialectically through a questioning responsiveness to the matter being encountered (Smith, 1983, p. 70). The method shows itself in the question, "what is the experience of a woman's transformation to mother?" Such a question calls for attention to women's voices of their own experiences in the situation of our present society. It is Our Woman that we need to understand—not an analysis of variance model of interaction that will not capture the experiential quality of life that Our Woman lives. We need to explore the lives of women. Decontextualizing women's experiences loses the meaning we need to capture. Therefore, we begin to see that the question points to a search for "understanding" rather than "explanation," in a narrower scientific or empirical-analytic sense. For this reason a phenomenological approach will be used—of which interpretation (hermeneutics) is an integral aspect.

Hermeneutic Phenomenology

Stated in a simple way, phenomenology has to do with description of experience and hermeneutics with interpretation. Such simplicity, however, contradicts the depth and complexity of the historical roots from which these philosophical approaches arise. Phenomenology is associated especially with the foundational writings of philosophers such as Edmund Husserl (1970, 1977), Martin Heidegger (1962), and Maurice Merleau-Ponty (1962, 1964). Others have infused the phenomenological project with a concern for hermeneutics (Gadamer, 1975; Ricoeur, 1973), a concern for a hermeneutical epistemology (Rorty, 1979), power (Foucault, 1975, 1983), critical theory (Habermas, 1968), textuality, (Derrida, 1973), and so forth. Most, if not all, of these approaches are fundamentally concerned with understanding the lived meaning of the life world—an interpretation of human experience.

> Phenomenological research edifies the depthful, the personal insight contributing to one's thoughtfulness and one's ability to act toward others, child or adults, with a tact or tactfulness.... We might say that phenomenology is a philosophy of the unique, the personal, the individual which we pursue, against the background of an understanding of the logos of Other, the Whole, or the Communal. (van Manen, 1984, p. ii)

The hermeneutic phenomenological approach of this study (based on the work of van Manen) uses both description, which is concerned with the lived experience of women in childbirth, and hermeneutics, which is the act of mediation between the interpreter and the interpreted

(Silverman, 1984) as a way to recover the nature of lived experience (van Manen, 1984).

Phenomenological research gives a "direct description of our experience as it is, without taking account of its psychological origin and the causal explanations which the scientist, the historian or the sociologist may be able to provide" (Merleau-Ponty, 1962, p. vii). To give direct description is an attempt to produce an accurate narrative of the experience. Such an account is a description of the meaning of the experience of being-in-the-world. Phenomenology does not try to explain, but attempts to understand by identifying the intentional structures of experience from an experiential viewpoint (Kohák, 1978). In this way life world knowledge is seen as different from other knowledge—performing a different function. Hermeneutics, an essential aspect of the approach used in this study, is concerned with bringing to language that which lies hidden. This is done by an attentiveness to the ground from which description comes in order to the reveal the possibilities of deeper understanding.

The strength of Merleau-Ponty's (1962) approach to phenomenological description is that the describer is embodied and involved in the experiential field which includes "motility, spatiality, gesture, and expression." Embodied in the research in such as way as to develop a deep understanding of the nature of the phenomena, I, as researcher, attempt to describe and interpret the lived reality of women's move to motherhood. I do this through reflection on my own and others experience without necessarily offering causal explanations and in doing so I recognize that my own experiences are the possible experiences of other and that other's experiences are the possible experiences of self (van Manen, 1984). This intersubjective nature of experience can itself be seen as a phenomenological universal, a normal feature of the life world.

Researching Lived Experience

When we talk about "lived experience" we talk about the experience of being in the world, the world of everyday life, the world as it is experienced.

> Lived experience is the "originary" way in which we perceive reality. As living persons we have an awareness of things and ourselves which is immediate, direct, and nonabstractive. We "live through" (*erleben*) life with an intimate sense of its concrete, qualitative features and myriad patterns, meanings, values, and relations. (Ermarth, 1978, p.97)

To speak of our lived experience in a strong sense is to go beyond the taken-for-granted. It is to uncover meanings in everyday practice in such a way that they are not destroyed, distorted, decontextualized, trivialized or sentimentalized (Benner, 1985). It is to explore the way in which women who are pregnant, give birth, and live with young babies experience the world. It is an intensified exploration of women's own realities—the shape of their own lived worlds (Greene, 1978). This exploration comes through ongoing conversation with women. It is a search for understanding of women who express themselves through their talk (Ricoeur, 1973).

The Conversations

In order to explore the experience of transformation as lived by women in childbirth, I have engaged in conversations with women before, during, and after pregnancy and birth. These conversations were of two distinct types, the one-time conversation, and the in-depth series of conversations.[1] The term "conversation" rather than "interview" is chosen to describe the actual process that was used. With each woman I talked about the nature of my interest—that is, to explore women's experience of childbirth (including pregnancy and post-partum). With some women, for example, the conversations were for investigating specific experiences, such as the use of the fetal monitor, or the experience of birthing pain, while six women were followed intensively from mid-pregnancy to a number of months of living with the child. These six women were all first-time mothers and most of the other women had had only one child. With all the women I encouraged them to talk about how it was for them, and in doing so to use concrete events as anecdotal examples. The following questions are given as examples of the ways I initiated or prompted converstions with the six women who became the main focus of the study:

> When did the possibility of children first come up? or did it?
>
> What kinds of feelings did you have when you found out for sure that you were pregnant?
>
> How did others in your life respond?
>
> What was your experience of body, space, time? Did you find yourself seeing, hearing things, or attending to things you did not before?
>
> What are the days like? At what times or moments are you reminded of your pregnancy? or the child inside you? What is it like? How do you feel?

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[1] See Appendix A for names and dates of these conversations.

Do you think ahead sometimes? What occurs to you?

Do you think about the birth? In what way? How do you feel about that?

Each conversation was listened to before the next interview so that aspects that needed clarification or follow-up would occur.[2] The atmosphere of the conversation was open and the effort was directed to have the women speak with as much specificity as possible about their own experience to clarify what they meant. "Can you give me an example?" was often my only interjection into their talk. (Phenomenological research has been call the "science of examples.")

There was a consciousness of the interaction between each woman and myself, in these conversations. The women were experiencing the birth of a first child; I have two children now twelve and fourteen years. The women were in their late 20s or early 30s; I am over forty. Their everyday lives were filled with work and home; mine with study of their experience, along with an intensive dwelling in literature of women, childbirth, and phenomenology. I was very interested in their experience, they were not exploring mine. But I was not merely a privileged observer—I was involved. At the same time as there was a sharing of a common concern and experience, the mutuality was inevitably skewed by the research intentions. But still as we talked together aspects of our lives were present—in the "in-between"—we came to the conversations as people (Gadamer, 1977).

In delineating the "in-between" it must be understood that in conversations of this nature both participants are immersed in the tradition of their own life history. It is from this position of shared history that understanding comes into being. At the same time, there needs to be full consciousness of the presuppositions and interests that are carried and there needs to be a recognition that these "common-sense preunderstandings, suppositions, assumptions, and the existing bodies of scientific knowledge predispose us to interpret the nature of the phenomenon before we have even come to grips with the significance of the phenomenological questions" (van Manen, 1984, p. 9). Therefore instead of "bracketing," that is, setting aside certain questions and assumptions, I am proposing to question the "taken for grantedness" to look at what is truly being said in the conversation. Such questioning allows for new understandings, new possibilities, that may go beyond the reality of the presuppositions. It demands a critical consciousness on my part to acknowledge and attend to my own presuppositions so as to arrive at the depth of the phenomenon (Kvale, 1984).

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[2] See Appendix B for an example of transcript material. These excerpts are included to show the reader the nature of the conversations from which the stories and the thematic interpretations were developed.

The Women

Women generally want to talk about their birth experiences. Over the years of my study I have spoken to many mothers. Some women were specifically interviewed for earlier versions of parts of this work. Others I met said, "I'd like to talk to you—I have something to tell." Then I was influenced by my presence at the homebirth of Paula (May 7, 1983). There were five or seven meetings with each of the six women who agreed to participate in on-going conversations over an extended period of time. At least one, Christine, has agreed to further conversations beyond the time frame of this work. Brenda and Susan were included through contact with their obstetricians, Anna and Katherine were approached through the midwife who planned to attend their home births, and Christine and Jane were recruited through friends and associates.

The nature of the study was explained to the women and as they agreed they signed a consent form which indicated their willingness to participate. It was understood that they could withdraw from the study whenever they wished. None did. The first conversation was held when each woman was five or six months pregnant. Christine's and Jane's babies are now two years old. Christine has another baby, and Jane and Anna are pregnant again. The other babies all are over a year. My relationship with the women has been friendly and enjoyable. One woman, Brenda, and her husband, agreed to my request to attend the birth of their child which took place in a local hospital. With each woman I sensed a feeling of mutual respect and openness.

The women participated in the study for their own reasons. Perhaps it was curiosity; perhaps they saw it as an opportunity to talk to an interested person about their own experiences; perhaps they thought they might learn something; or perhaps they wanted to contribute to research in this area. For whatever reasons that the women participated, they gave generously of their time, and more importantly, of their experiences, thoughts, and feelings. They allowed me to

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"touch" their inner experience of transformation as well as to discuss their outward reactions and perceptions of what was taking place in their lives.

Two of the women's husbands shared in some of the conversations and over the period of time I had the opportunity to meet all the men. Although my primary interest is in women's experiences, the women's involvement with their men was an important element that ran through much of their talk. All the women seemed to have strong and committed relationships during this period of time. All but two of the ongoing conversations took place in the women's homes. The two exceptions took place in the privacy of Christine's office. Brief hospital visits were made when possible and the first post-partum interview was held as soon as possible following the birth. I had originally planned to take notes during the interviews but abandoned this procedure because it took away from the focussed attention needed for the talk. All the conversations were tape recorded and transcribed. Considerable disruption occurred during the interviews that took place following the births, demonstrating vividly the changed character of the women's lives.

Conversations with only six women may seem to give a limited view of experience. However, each conversation offered a rich and deep wealth of material that demands even further exploration and in no way do I expect that this analysis is a conclusive or final commentary on women's transformative experiences of childbirth and becoming mothers. It is offered as one possible interpretation of women's lives, recognizing that there *is* no conclusion for questions of this nature. Striving for deeper understanding is an ongoing project.

The Stories

Knowledge has been lost in the surge toward "research data" and "information," which to be considered valid must be objective, factual, and replicable. Stories, in contrast, are contextualized, personal knowledge, never replicable, and full of life experience which is not explained. Thus, with stories, nothing is forced on the reader, as with interpretation or analysis. The reader can enter the story in a manner that ties the reader to the story in a personal way. Benjamin (1969) said that the loss of storytelling as a valued enterprise is related to the changed "face of death" in present society. He said that people are "dry dwellers in eternity" who at their end are stowed away in sanatoriums or hospitals (p. 94). While once the death of a person could release the story of personal knowledge and wisdom—"the stuff of real life"—the hygienic approach to death has led to a loss of the authority of storytelling.

The story, however, offers a way to approach human experience. What can be recaptured in storytelling are the images and incidences of everyday lives, in the women's own words— reaching "below the surface.... to extract that part of a person's experience which others can incorporate" (Kotre, 1984, pp. 26, 30). Storytelling is an interpersonal event with traces of the storyteller clinging to the story—like the handprints of the potter on the clay vessel (Benjamin, 1969). In this way it is different from journals, diaries, memoirs, or autobiographies (Kotre, 1984). Stories are not instances of the individual's principles, but are rather the context within which the principles acquire sense.

From the conversations with the six women the stories were developed. Each woman's story is unique with its own rhythm. Its authority is heard in the listening (reading), which the hearers (readers) interpret from their own experience. In chapter three I have taken excerpts from the transcripts and reconstructed each woman's story that reflected what stood out in her talk and which seemed central to her life. I did this by thinking about each woman and asking myself, what was the nature of her talk? What were her interests and concerns? How did she show herself to me? Presented in this way, the stories introduce each woman and tell her story in a way that reveals the landscape of her life—her situation and context from which her words came. With understanding and respectfulness of the complexity of these women's lives, and all human life, the story that characterizes a particular woman's life is, naturally, recognized as a simplification of that life.

While the writing of the stories comes out of my reflection on our conversations (that is, there is choice in the telling), the words belong to each woman. Nothing is fictionalized. The women were invited to read and comment on their story as it is presented. Each agreed that she was able to see aspects of her experience in the story. On the one hand, it is be acknowledged that as a story captures only a few aspects of a particular woman's life, it may be less truly her personal story but another version of Our Woman. On the other hand, it can also be the case that the retelling, the interpreting, the focussing and the shaping may make for a different and, in some sense, a better understanding of a woman's life.

Finding the Themes

As I read the stories I began to notice that each story somehow characterized a particular theme. It was as if the themes, or moments, came out of the stories themselves—they "showed themselves," in a sense, as they were discovered after the stories were written. Moreover, in reflecting on each woman's uniqueness, and what stood out of her individual story, it was realized that, in reality, these moments were found in the other women's stories as well. It would have been easy to create dialogue among the women themselves on these overlapping moments. The use of the word "moments" instead of the word "themes" seems to capture in a better way the special aspects that are highlighted through the stories.[3] These moments are not periods of time, although they occur over time, but are identifiable aspects of this experience that interact together to show the nature of this transformative experience.

It is important not to make too much of thematic moments. True, themes of experiences are principles or essences of the experience that make the experience what it is. For example, it is true that coming to a decision about having a child is part of all women's move to motherhood, yet, for each woman, the decision may be experienced differently or may not be dealt with, thoughtfully, at all. Consider, too, the theme of responsibility. Responsibility is an important aspect of the move to motherhood but may be realized in different ways and times by individual women. It is also true that there may be other moments that could be found, such as the woman's changing relationship with her mother, or the changed recognition of the importance of grandparents. These identified moments should rather be seen as "knots in the webs of our experiences, around which lived experiences are spun, and are experienced as meaningful wholes," (van Manen, 1984, p. 29). Thus thematic moments are not magically appearing essences, but are useful focal points or commonalities of experience around which phenomenological interpretation can occur.

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[3] The words "themes" and "moments" are used interchangeably in this study.

Thematic Analysis

There is a great contrast between the story and interpretation. The interpretation of the thematic moments presented in chapter four to nine represents further hermeneutic work with the texts of the transcripts by: tracing etymological sources, searching idiomatic phrases, exploring other childbirth literature and artistic sources and by attending to personal experience (van Manen, 1984). Through thematic analysis I explored the women's words to discover the forgotten, hidden, mysterious, or ambiguous nature of their experiences. These dimensions of meaning a person cannot easily discover by herself or himself. It is a hermeneutic project—an interaction with the various materials (texts)—that discloses meanings, like the wing-footed god Hermes whose task it was to make intelligible to mortals the messages of the gods (Silverman, 1984). The possibility of phenomenological interpretation is to produce or establish meaning by exploring the situation, the choices, and the actions that describe the meaning context of experience.

> The stress is not upon the subjective interests of the interpreter nor upon the objective features of the work itself, but on the art of interpreting and the significance of the interpretation that is produced. Phenomenological description is an account of the meaning of something, phenomenological interpretation is the *act* of producing or establishing a meaning. (Silverman, 1984, p. 22)

Through the dialectic going back and forth among the various levels of questioning there is a striving for a thoughtfulness, "a deeply reflective activity that involves the totality of our physical and mental being" (van Manen, 1984, p. 28). In one sense, it was an exploration of self, forcing a self-reflective attitude. I have needed to attend to the question of "Who I am?" as a woman and as a mother. This opportunity for a personal turn in my life (also identified by Novak, 1978) was not of my own choosing—but came as a gift to be treasured.

Writing and Rewriting

Phenomenological writing is an integral part of this research approach. The writing, as interpretation, strives for a poetic (disclosing) quality in that it attempts to bring to language the thematic moments in such a way that the essence, or the lived-through meaning of the experience shows itself. Phenomenological writing and rewriting is the project of interpreting the exposed themes.

To organize the writing the existential themes of temporality (lived time), spatiality (lived space), corporeality (lived body), and communality (lived relationship to others) have been woven into the story themes which came from the women's lives. Along with this visual structuring of the writing the effort was made to search for deeper levels of analysis, to vary examples, and to explore and engage in a dialogical fashion with other phenomenological authors. It is immersion in language, the shared meanings, that makes the hermeneutic process possible. Language both reveals and conceals—providing for a unity between the said and the unsaid (Gadamer, 1977). "More is meant than intended in each expression, and thus the hermeneutic process is needed to explicate the unsaid" (Idhe, 1983, p. 151) It is a project that moves from life towards thoughts, not backwards to the author, but forward to its meaning and toward the sort of world it discovers and opens up (Marcel, 1978, Ricoeur, 1973).

Habermas (1968) outlined three types of knowledge arising from particular interests—an interest in understanding, technical interest and emancipatory interest. The interest of this study has been in understanding—yet the underlying concern has been emancipatory. The possibility of getting beyond the surface level of the phenomenon, to the deeper than conventional wisdom, implies a critical stance. It has action potential, suggested by the question, "How do we create a world that supports and encourages women with children to live as mothers?" More specifically, my critical interest is related to health care and nursing. "How does the woman come to know herself as mother in our present maternal care environment?" "What does it mean to be a nurse in the midst of women's transformative experiences?" The emancipatory, critical aspect is inherent in the entire work.

Limitations

As I come to the completion of this work I have greater awareness of its limitations. Some of the limitations are implicit in the method and may easily be identified, while others are more problematic as they are not so easily seen. In this study, there was no expectation that results would be arrived at which would be generalizable to all women who become mothers, that the study would be able to be replicated to yield the same data, or that a description of a transformative experience could be understood in such a way as to lead to measurement or even to comparisons between women's transformative experiences. Research into matters profoundly human, as attempted here, cannot be generalizable, reductionist, or measurable. In order to evaluate and extend this work, a study using a similar approach, in conversation with younger women for example, or with women from other cultures would provide the opportunity to come to a deeper understanding of women's transformative experiences of becoming mothers.

The more problematic limitations of this study may well be found in other directions. Parse, Coyne, and Smith (1985) suggested standards used to guide evaluation appraisal: the soundness of ideas (supported by appropriate evidence), the presentation of ideas (organized in a succinct way with clarity and integration), the attention given to the self-determination of the participants, and clear explanation of the methodological and interpretive dimensions. Yet as I consider how soundness of ideas is evaluated, I recognize that with this work the soundness of the ideas may not be seen until the work is brought into discussion with others, as Feuerbach (quoted in Bollnow, 1974, p. 12) suggested, "If I can see something, I can also be deceived; only if another sees it too and confirms it for me, do I know that it was no deception." Bollnow clarified this notion further: "The community and universality of truth means that we engage with others, in full reciprocal openness, and that in such a testing and clarifying dialogue we stand on the common ground of rational discussion" (p. 13).

It would be easy to hold back from discussion of the work because such openness requires courage to place oneself in question. The limitations were brought to test as I gave chapters three to eight to Susan, Anna, Christine, and Katherine for their comments. I felt vulnerable and reluctant to present an analysis of their conversations, yet it was essential to do so. I was encouraged by their responses. Each woman carefully read the work and commented through writing and discussion. Two of the conversations lasted almost two hours as we explored, clarified, and expanded the various ideas. It would have been worthwhile to have had all the women discuss the work together. Some of the written comments were:

> What I found most interesting was discovering that the other women in the study had many similar feelings and experiences as I did—feeling the vulnerability, a change in treatment by others, and even something as trivial as lack of choice of clothing. . . . All of us had made the decision to have children and then having conceived were struck by the

> overwhelming feelings of uncertainty. It was reassuring to know other women felt the same. (Susan, Personal Communication, June 16, 1986)

> It was indeed a transformation for me. . . . I was interested in those things that seemed common (the inwardness one feels during labour), and how we differed (how we felt about our changing bodies). There is great strength derived from birthing and mothering and I think it is an untapped resource. (Christine, Personal Communication, June 8, 1986)

My own experience of being a woman and a mother influenced this research. While giving me the inside view of the truth of women's experiences of becoming mothers, it also had the potential of putting my life in question. "If, as I have stressed, truth is something profoundly painful which cuts into our lives," said Bollnow "then strong self-discipline is required in order to bear this pain and whoever is afraid of himself will find some excuse to avoid the burdensome truth by suspending further conversation in this area or by turning to something less threatening" (1974, p. 15).

It is not fully apparent to me at this point what truths have been avoided or suspended out of reluctance to face issues that question myself and my life. It may be that these limitations will only be dealt with as I continue to explore the data with courage to rethink, discard, clarify, expand, and deepen the ideas researched here.

Organization

Chapters 1 and 2 have developed the horizon from which this study begins—showing the question, the approach, and the parameters of the study. Chapter 3 introduces the question of transformation with the women's stories. Chapters 4 -8 explore the meanings revealed through the thematic analysis, and interpretation of women's experiences. In Chapter 9 the moment of birth becomes a concrete example in which to explore the differing approaches to knowledge in relation to women's understanding of themselves as mothers. In Chapter 10, as the concluding chapter, I focus attention to thoughts about nursing, and offer several theses as a result of my involvement in this research.

Chapter 3

TOWARDS AN UNDERSTANDING OF TRANSFORMATION: THE EXPERIENCE OF BECOMING A MOTHER

Women's Talk

> The subject of birth has, inevitably, its own compelling attraction. No one who has given birth or witnessed it ever quite forgets. Mothers relive it secretly, or reflect on their own experience among each other for many years afterwards. For a story that is, essentially, always the same . . . the essence is always new, always dramatic. . . . It was the same for Cleopatra, for Marie de Medici, for Anna Magdelena Bach and Sophia Tolstoy and Sophia Loren and—Eve. I was in good company. (Sorel, 1984, p. xvi)

Women tell each other about their childbirth experiences. They reminisce about labour and delivery. They talk about how they felt, what were the good things, and what they wished were different. The stories are told around kitchen tables, at baby showers, at bus stops, over cups of tea, almost anywhere where there are pregnant women and mothers. In spite of the fact that almost all births are normal, that is without medical complications, it is often the horror stories of labour and delivery that are told. "I am afraid 'cause everyone tells me all those stories about when you have your first baby, you are in labour for hours, and hours, and hours, and hours," said a young pregnant woman. Brenda, a participant in this study, said, "I find a lot of people will tell me horror stories. They always tell me the worst, the bad things that can happen. I just take them with a grain of salt, I have to take this in my stride (B1)." Is it for dramatic effect that such stories are told? Is it because women really have had such a bad time?

Through the talking many women come to realize that they may have missed an important aspect of their lives as women. Women who were unconscious, sedated, or were subjected to Cesarean deliveries question their experience. Others, like Christine, said, "I'm glad I didn't miss it—the pain—the work. It was something I did not want to miss" (C1). A few years ago a newspaper columnist wrote a series of articles tracing the change in birthing practices over the last thirty years (Sweet, 1983). Many women, in response to the series, wrote or telephoned the paper with stories that were traumatic, "heart-breaking," according to the columnist. Through sharing their own stories, women have begun to realize that their individual unsatisfactory experiences were not just personal failures but were experiences that were shared by others (Jordan, 1980,

p. 86). "Who among us has not been dumfounded at the realization that those problems so modestly brought up [in conversations] were the lot of almost all women" (Faure, 1981, p. 83)? Women's changing consciousness, revealing the dark side of their common experiences of childbirth, has brought about change, such as universal childbirth education classes, the routine presence of fathers in the delivery room, the return of the midwife, and other humanizing practices. Chesler (1979) wrote, "There's a shelf in my local bookstore marked 'Child Care,' with books by male experts on annual expected growth rates and separation anxiety; books praising natural childbirth; books damning obstetrical practices in America. . . . I find [only] a handful of precious, brave books, all published in the last five years, by mothers on motherhood" (p. 4). The stories of women, by women, are beginning to surface. Thus, instead of shrinking women's experience of birth into clinical terms or breaking it into fragments through much of present day research, the sharing of experiences among women is directed toward the construction of new meanings true to the reality of their lives.

Women's talk has real value, for talk is the very vehicle for change—for re-creation of the world in their own voice (Berger & Luckman, 1967; Gilligan, 1982). Some women talk and write about childbirth for their own personal reflection, while more and more are writing to share with others (Chicago, 1985; Barrington, 1985, chap. 7; Sorel, 1984; Ashford, 1984; Dowrick & Grundberg, 1980; Chesler, 1979: Kitzinger, 1978). Many women want to know about childbirth and mothering, especially those women who are pregnant. They "search for Mothers, dead and alive, to guide them," said Chesler (1979, p. 5). Judy Chicago (1985) in describing her work of the *Birth Project* talked about meetings where women speak about their birth experiences. "It was spellbinding and very moving. It made me wonder why there has been so little art about birth" (p. 19). Childbirth is an important life event, an experience that needs to be uncovered and perhaps re-discovered by women themselves.

Becoming a mother is an inner journey for women. Of course, it is an outer one too—marked by the burgeoning waist, the ballooning clothes, the awkward gait, and for many, a radiant and wholesome face. The integrated reality of both the outer and the inner process will be traced through listening to and talking with women in the midst of their own experiences. O'Brien (1981) argued that it is "from an adequate understanding of the process of reproduction, nature's traditional and bitter trap for the suppression of women, that women can begin to understand their possibilities and their freedom" (p.8).

The Stories

There are women everywhere with fragments
gather fragments
weave and mend
When we learn to come together we are whole.
(Cameron, 1981, p. 149)

By gathering the fragments and threads of women's lives, from their individual stories, it may be possible to weave an understanding of the transformation that women who become mothers experience. Let me present the women and their stories: Brenda, Christine, Jane, Susan, Anna and Katherine.

Brenda

Brenda and Tom live in a new city development, the houses spaced "inches" apart. Two large dogs meet me at the door as I visit for the first time. Brenda is 26. She has always thought they would have a child sooner or later.

"We have been married 5 years this December and we decided that we have our house, have our dogs, have our vehicles, so it is more or less time. Actually I wanted to wait another year, but I will be 27 next week and if we want two children, I'd better get started. Tom really did not want to wait, so I agreed to have the IUD taken out with the hope that it would take a few months to get pregnant.

"But 2 weeks later I never got my period and I was shocked. I was shocked and I cried. Tom laughed because he was so happy, ecstatic. Just like a little kid. He had wanted children for so long.

"I said, 'No, Tom, this can't happen that fast, no way.' And of course, I was. The first reaction was upset. I thought, 'How could it happen so fast, here I am going to be a mom and I don't want to be a mom just like that.' Thank God it takes 5 or 6 months before you really start to show.

"It was just shocking. I spent the whole summer being sick. Morning sickness. At work, with all the heavy lifting, I'd get cramps. And the sun. It was such a beautiful summer. I would go outside for five minutes, and I would be upstairs in the bathroom again. Or we would go camping and I'd be sick the whole time, from the time I got up until the time I went to bed. It went on all of June, July, and August. It was near the end of August I started to feel better. In a way you could say I was talked into getting pregnant. But I'm not sorry now, but at the time I was. 'Tom, how could you do this to me!' That kind of thing.

"At work, people drive me crazy. It's, 'Mom this, and Mom that.' Just to get used to people coming up and wanting to touch your belly, like there must be a hundred staff in that store, and they are so thrilled to see a pregnant person, and they come up and want to feel your baby kicking. It really embarrasses me. But what do you say? 'I don't want you feeling my baby.' Like it is too personal, and they want to know everything. Like, 'were you sick this morning?' and 'did you drive to work?' It gets to the point, 'Leave me alone, I am only pregnant, not a baby!'

"In a lot of ways the baby comes first for other people. They say, 'Brenda, you shouldn't be doing that.' 'Your hands shouldn't be over your head, you shouldn't lift that.' 'Yes dear,' I say, mocking them. 'Yes, I won't do that anymore, I'm sorry, I was a bad girl,' and then I would turn around and do it.

"And I've noticed that you go into a crowded place, and a lot of people look at you and smile. Whereas before you could just walk in. When you go to a place, like Saturday night we went for a drink in a lounge, and I find that people really make you feel uneasy, like you are doing something just terrible, and you are only drinking orange juice. Like 'come on!'

"I want to go back to work. I get so bored if I have two days off in a row. I like to get out and do something. I don't like to be stuck at home. But maybe with a child, you would be doing things. We have a lady next door who will babysit. I'll start going back in the evenings and Tom will babysit. But like he says, 'I don't want to sit in the house every Saturday and babysit.' It is the same for me, I don't want to feel that I have to do everything with the baby. I want to have my own life too. If I want to go out with the girls, I should be able to.

"I am going to bottle feed. That was a major fight. Tom believes in mother's milk. And me, just being the type of person I am, I just have an aversion to it. Even if I see someone else nursing it kind of gives me the creepy-crawlies. It is a natural thing and I know it is good for the child and I've heard all the good points about it. But it is just not for me. Its good old formula. Thank goodness they have invented those things.

"Our best friends have a 3 month old boy, and like I have yet to pick it up or anything like that. I am not the type that wants to cuddle or hold it, but they say it is different when it is your own. We will wait and see.

"I would rather have a boy, I don't think I want a girl, mainly because Tom would be too strict with her. I am sure if we had a little girl and she was out playing for two hours, and he didn't see her, it would be like twenty questions. 'Where were you?' 'What house were you in?' 'Who were you playing with?' He wouldn't do that with boys. He does it with me too. Like we will go into a restaurant, and I will ask for something, and he will say, 'No, she doesn't want that, she is pregnant, she is having this.' I get this stunned look on my face and when the waitress leaves, I say,

'Tom, do you realize what you did?'

'No.'

'Tom, I asked for coffee and they are bringing me milk. I don't want milk.' He feels embarrassed but I don't think he would notice he was doing it to a girl. Anyway I think it is going to be a boy. We would be happy either way, but I have always felt that we are going to have boys. We have two girl dogs, and will have two boy kids.

"I find it, my body, really hard to accept. You understand that this is a baby growing inside you, and you have to get bigger, and you see your body growing different, and there are deposits of fat and stuff. It disgusts me. So far it is hard, its firm, but you know that it will be jelly-like later on. It is hard to accept. I step on the scales, and I say, 'I weigh that much?' I believe that you can have a child and you can go back down to 115 pounds afterwards, there is no reason why you shouldn't. I feel that I should be the way I was before.

"We saw a film about natural childbirth and Cesarean section at the prenatal class. I kept my eyes closed, 'Just let me know when it is over.' Tom was really impressed. Now he wants me to have a Cesarean. He says it is more humane, like he doesn't like to see a woman suffer. He figures it would be less pain. I think it would be harder on your whole body with getting used to the baby and not feeling as well as you could. I don't want it but I don't think I will have any choice in the matter. Whatever is going to be is going to be."

Later, at the hospital . . .

Brenda was moved to the delivery room and when asked how she was feeling said, "I don't know. I just want to get this over with."

Everything was happening so fast. The doctor came in, gowned, and put her feet in the stirrups. Although Brenda mentioned the cramp in her leg there was no attention paid to it, there was no time to attempt to relieve the cramp. The doctor said that on the next contraction the baby would be born. He cut an episiotomy, and the baby slipped out. The baby responded quickly and cried.

"It's a girl!" said the doctor.

"No!"

"I am going to put the baby on your stomach."

"No, please don't."

The doctor then held the baby until the cord was clamped which was almost right away, and gave the baby to the midwife who wrapped it and put it under the lights in the bassinet. Brenda commented about having a flat stomach and smiled when she talked of it. From the end of the room, the midwife involved herself with records and procedures. The doctors repaired the episiotomy and the obstetrician again asked if Brenda would like to hold her baby. "No." Her head was turned away from the baby.

In masks covering our noses and mouths, Tom and I stood and looked at the baby. She was beautiful. I wanted to hold her, and suggested to Tom that he might. Neither of us did.

Christine

"We had ten years together without another person with us," Christine pointed out over a cup of coffee. We sat at the wooden kitchen table that, I guess, she and Nathan had built together.

Her home showed care and effort: the stained glass in the front window caught my attention as I arrived. Christine talked of her life with Nathan. "We always have lots to come home with, we talk about our various jobs, we know a lot about each other's work, and we can ask each other's opinion about this or that problem to which we can comment knowledgeably because we are close enough to know what goes on," she said.

At home, also, their work was shared. When they bring lumber and supplies for the various projects they, together, haul the stuff into the house. Generally Nathan does the constructing and Christine sands and stains. She said, "We have been very equal partners in sharing, both in the household chores and income and in our expectations of working together for certain goals, financial or otherwise." The money they shared was their money not his, or hers, but from a common pot.

What would bringing another being into their life do to this shared adventure? Christine wondered. What would it mean to them?

At 32 years, Christine wanted to make a decision about having a baby. Up until she was 30 her focus had been on her career. She desired to do her own work, to fulfil ambitions, and yet the possibility of a child in her life kept coming up. She did not want to turn 36 or 37 and feel that the decision had been made for her, that she had missed the time for children. In her need to make a decision, she began to pressure Nathan. He did not like that very much. "It puts your relationship in jeopardy," said Christine. "Could having a baby be the biggest mistake of your life, as Nathan thought? Could it really smash everything?" "Whether or not to have a child" gave them some "heavy-duty" times for some months, with Christine crying and Nathan "up-tight." So they decided to find a third person, a counsellor, to "mediate the decision."

"What made this decision so tough?" I wondered. "I've seen women in my work," said Christine, "who look like they have been gobbled up by children and a household and a husband. These women are trying to be very good mothers, and spend a lot of energy doing that. They look after their husband and their children and are responsible for keeping the family together. I've seen women who have lost themselves, in a sense. Everything is for their children, or somebody else, and not them, whether they have a career or not." She talked about the plight of 45 to 50 year old women who, after the children have left home, are lost. They do not know how to do simple things that most people cope with in their daily lives.

Christine gave an example of a bright woman who held a top role in government. This woman had done such amazing things. Christine wondered, "Would she be there if she had children? Is it possible to do both? And yet, some women manage all kinds of quite exciting things, and still have a household and children and the whole thing." Christine puzzled, "Will I lose myself in becoming a mother?

Christine described her pregnant friend who went to the bank to get a loan. This friend had said, "I think it was hard for the bank manager to talk to me. He seemed quite anxious that I was pregnant, 'if I was sitting comfortably,' or 'if everything was alright.' And I was there to get my $5500 loan! They don't treat you like any other person, with questions about your employment, your salary, and so on." This furthers Christine's puzzlement, "Why, if you are with child before or after birth, are you not still a woman?"

Looking after a child may be overwhelming. "I keep thinking," said Christine, "I might be too tired, too bogged down with a zillion diapers and maybe a crying baby, and all the millions and millions of tasks involved with a baby." She elaborated, "You see, work is manageable, you know what you can do, you can have it organized, and you know that you have done this for ten years. Nathan thinks I might get bored at home and wonders what I will do with my time, and I'm just bowled over with the thought of it. I just hope I would be able to make it over the first few months."

And then, what will change in herself? "I wonder about the dependency . . . It is not something I would want, and I know Nathan would not want. It is because it is an unknown and you have nothing to compare it to, nothing! I think it will make a difference in my life, but still at the back of your mind I question that change. We know there will be change but we can't anticipate making it. It diverges the course of your life forever, and that is not necessarily bad or good, just that men never have to truly deal with that, ever."

Nathan talked to the counsellor first—by himself. "The guy sure didn't work hard for his money," laughed Christine, "as the issue seemed to dissolve itself." She remembers walking the dog after being through all that, after the decision was made, "Yes, we will go ahead and have a family." Nathan, on the walk, quietly asked, "Well, how do you feel?" Aren't you still afraid?" She was.

Christine was visiting her family in the East when she realized she was pregnant. She waited to tell Nathan when he arrived. They were swimming with the family when Christine went up to the cottage. She called Nathan. "I'm pregnant," she said, "but don't hold your breath. I'm bleeding." Nathan was very shocked and said, "What shall I do, what shall I do?" Christine said, "Nothing, just let me stay here. You go down to my friends and carry on." She was very upset and thought, "After finally making the decision, now what if I couldn't have kids?"

Jane

From the first talk Jane hinted at the possibility of some change coming in herself as she moved along in pregnancy. She said, "I never really liked kids. I remember talking to my sister-in-law about whether or not we could be mothers because we are not all that gung-ho on children, but everyone assures me that you will like your own, that it will be all right. We kind of questioned whether it was true."

Jane was ambivalent throughout her pregnancy. At six months she said, "There are still times when I am not sure that I want to be a mother. It is a little late now," she goes on with a laugh, "but there are still times when I do not want to give up the freedom. And I'm thoroughly enjoying my job that I have now. And I am afraid it is going to change our relationship. We have had such a good year, such fun. I really don't want our relationship to change."

Both Jane and Jim talked about friends whose relationship had deteriorated, they thought, with the coming of a child. These parents doted on their boy, talked of nothing else, laughing at his antics—"which even," much to Jane's disgust, "included grinding cheerios into the rug!" And about those couples who let their child rule their lives, controlling when they would come to dinner or have a night out! Even on the way to the hospital, in intense labour, Jane expressed doubts about their decision, "I just don't know if we are doing the right thing."

But a year later she said she would like to have four children, "with no hesitation at all!" "I was afraid children were really going to change our lifestyle so that it would be a problem for Jim and I and our relationship. But it hasn't, it's grown in a lot of ways. We both enjoy her so much."

I wondered how this dramatic change had happened.

Early in her pregnancy Jane noticed that she saw pregnant women, and mothers and babies more. "We (she and Jim) both have noticed babies a lot more than we did before," she said. "We notice pregnant women more, watch them, watch what they do, if they are smoking, or drinking, how big they are. The other day Jim and I were at a restaurant, and Jim was telling me what a great day he had had. I was watching these two kids from two different tables playing shy and watching each other, and was not paying any attention to Jim. He looked around,

'What are you looking at?'

'Those two little kids.'

'You've never paid any attention to kids before.'

"And he is right I hadn't. But I want to know how parents react to their children and how parenting differs. I don't know anything about parenting, I've never taken a course in it, and nobody offers one. It is a very, very, scary thing, a very big thing. In a lot of ways, it is probably the most important thing you do in your life. We are just supposed to pick it up, and I don't know if I can just pick it up. But we both have had very good parenting, so that should help."

Jim reminded Jane of the time she came home from work and had cried for what seemed like two hours or more after seeing a baby that Jane thought was neglected. Jane explained, "This father came in—it must have been one of those really cold days in December—and this baby must have been, uh, only weeks old. The father came in with the baby wrapped in a thin blanket. The baby, covered with guck, had crocodile tears running down her face and the father was doing nothing to comfort her. I took the baby, which I would never do in my life, because I don't like kids and I don't like dirty kids. But I held the baby and gave her a soother and she was as good as gold. Later the mother came in and seemed very annoyed that I had her child and she took it and laid it in her lap and ignored it again. I felt so sorry. I was really moved by that, really upset."

Later (at eight months) Jane said, "Um, I'm not so ambivalent now. The baby kicks and I can see the little appendages sticking out, and that makes a difference. It is alive. It is a real thing. I am still apprehensive but not as ambivalent."

We were sitting in her living room admiring her beautiful baby carriage. "At first I kept staring at it," she remarked, "it is the same size to me now as my carriage was when I played dolls. So the carriage feels like I'm sort of playing house. But then I realize, of course, that that is not true, this is the real thing, the bigger deal. Then the furniture becomes foreign. 'What am I going to do with this stuff and all the clothes that various people are making?' They would fit a doll." Jane told about visiting her sister-in-law and new baby the day after the birth. "We saw this little baby, and it was tiny, tiny, ever so small. I wondered how I could relate to such a little person who didn't smile, wanted just to eat and sleep all the time. No one prepares you for that. It is a lot easier to carry it on the inside."

After Lisa's birth Jane said, "I do a lot more giving than I did before, I have to because Lisa is so much more dependent than a husband ever is. So that changes my perceptions of myself. It also makes me feel pretty good that I can provide for her. I don't think I have lost anything. I can go back to being the person I was after Lisa's grown up or after she's gone to school. I can go back to working and making money and being a provider when she is older. But I can never go back to the time when she's young and I really enjoy it. The whole nursing issue really struck me. She started eating solids at six months, so that meant that I was totally supporting her life for 15 months. And that really made me feel good, that's a real achievement. I don't have to have a paycheck to prove who I am, even though I thought I would."

"Do you talk about Lisa a lot?" I asked. "Yeah, all the time. Jim and I sit and talk about her all the time ... but she is so fascinating. We find her so, anyway. Jim and I also spend a lot of time talking about our relationship, and how—that is another we were not prepared for—how much time babies take away from your own relationship. We don't have the same time together, the close times. It is not as easy as I thought it was going to be."

Yet six months later Jane said, "Our relationship has always been good. We feel very fortunate. Jim is so understanding. He is feminine in a lot of ways, in the way that he thinks. He cares what I think, very caring and open, and also very patient. With Lisa it's enhanced. We kid about what we're going to do to her, how soon we are going to have to "lock her up" . . . and put braces on her teeth. . . . We have a lot of fun with her.

"How do you suppose this change has come about," I mused. "I suppose part of it is the working towards having the baby—doing all that hard work. Or just the creating and seeing this thing come out of your own body in birth. And also partially because they are so helpless. There is no choice. I guess it is just that they are so helpless and you really feel that you have to care for them and also when she came out she was looking at both of us, very intelligently, almost as if she recognized us by our voices or something. It is just so overwhelming that you can't turn her down."

Susan

"It is worse than a headache. I must admit that it is worse than a headache." Susan is speaking about the pain. Before the birth she had wondered if the pain of childbirth could possibly be worse than the headaches she gets. Her headaches last for a day and a half sometimes and she manages them so she hopes that labour will not be worse. But it is worse! "It is just more intense, quite a bit more. When they asked if I wanted something for the pain and Paul wondered if I wanted to wait, I just said, 'No, I don't want to wait.' So they gave me Demerol. But it doesn't take away the pain. It just made me woozy and sleepy in between."

Susan experienced the pain as low groin pain which radiated a little bit back into her hips, but not her back. And she didn't want anyone touching her. Although Paul was willing to rub her back or her shoulders, Susan could not stand it. So Paul helped her with her breathing. She said, "I'd look at him and he would help me out and do it, so it was really good—worked really well. And I kept trying to think about the baby coming out, that it [the cervix] is just opening up, that the pain is good. I kept trying to think it was positive."

Susan and Paul had waited so long for this baby. They had only been married three years but it seemed to Susan that having a child would just never happen. In fact, it was through having a uterine lining biopsy that Susan found out she was pregnant. She could not believe it! When they told her she was pregnant, Susan almost fell over! "I was in total shock because we had applied for adoption and were going to have the home visit in the summer. I had just finally decided that we wasted enough time waiting. It puts your whole life in a different perspective because you are constantly thinking, 'Maybe this month,' and you would get your hopes up, and I was tired of it. So the initial reaction was absolutely—I couldn't believe it!"

"Did you have any sensation that you were pregnant before this?" I wondered. "Well, the only thing I had noticed, and this had happened to me one other time, was that my breasts were really very, terribly sore. Like I couldn't run around, you know, couldn't go up and down the stairs. But this had happened once before and, oh no, I wasn't pregnant so when it happened this time, I was so fed up with my body not doing things right, that I thought, well, I'm not pregnant. I have a feeling, now, that I might have been pregnant before—but I don't know. I had said to Paul, 'I can't stand my body doing this, it does it all the time for me.' And he said, 'You think you are pregnant every two months, so don't worry about it, this always happens, and you are not, you know that'."

And then they found out she was!

Susan has striking colouring with fair skin and auburn hair. Just this year she had moved to teaching in a grade one class after many years of working with older children. She would never have made this move if she had known she would be pregnant as her work load doubled, especially during the first weeks of September. In the summer she had had the odd queasy day but generally felt good. "I have trouble with my legs, the joints, and in my back. I guess I notice that. And leg cramps, a charley-horse and it hurts the next day, it is so tender. But it is not bad. Maybe because we waited so long to get pregnant that I'd go through a lot before I would complain.

"It is really funny, I have always thought that pregnant ladies looked really great. It is not that I don't like how I look, but I am somewhat self-conscious at times. I wanted people to know that I was pregnant and not fat. And we went to a dance and I was wearing a sort of loose dress, and I felt funny dancing. I don't know why. It is not like I am humungus, you know, it was just sort of, I guess I felt a little self-conscious dancing."

The children in her grade one class were interested in her changing shape. Susan heard two little boys at the back of the room,

"I think she is having a baby."

"No, she is not. She is getting fatter."

"She isn't. She is not getting fat because getting fat is not a nice thing to say about ladies."

Susan was very conscientious about what she ate. "I really watch it. I feel guilty when I don't have my veggies for the day. But I also feel a little rebellious. There seems to be so much pressure from people that you have to do this, you have to do that—'How can you deprive your child?' I have quit drinking, and no coffee, and I had a can of Pepsi, and someone reminded me of the amount of caffeine in that, or I accidently stood in front of the microwave, and it was 'oh my god, what are you doing standing in front of the microwave.' It is almost to the point where, 'for goodness sakes, guys, you know, one cup of coffee is not going to deform my child, or a half a beer.' It has gone to the extreme. But I am definitely trying to eat well. I've had lots of energy. It is much easier than I ever thought it would be. And I'm working harder than I've ever worked for a long, long time."

For Susan, too, clothes were troublesome. "Thank God I can sew my own clothes. My coloring makes it hard for me to wear reds and yellows and blacks—those are the big colors. This year royal blue is big, so everything is royal blue. And nothing in greens or beiges or browns or the colors I like, there is nothing. And a lot of them are 'cutsie', too. You know, things with buttons that say 'baby.' And little frills and tucks and bows. You see, I think people notice you when you are pregnant, and I don't mind if I look okay but if I don't like what I am wearing, then I sort of feel self-conscious."

Early in her pregnancy Susan was concerned that she would not be able to stand up to her doctor, or that she would get worried if things were not happening when everyone said they should. She seemed to be more vulnerable than usual. "That is not how I was before, to get worried about every little thing. But now that I am pregnant, little things like that will get me wondering, 'gee whiz, maybe they are right, maybe I should be feeling it move sooner'.

"And because I wanted to change doctors I was really wondering how I was going to tell this man." She wanted to change to a doctor who worked in a partnership so that she could be more sure of who would deliver her. She had heard that some of the doctors were "butcher types." A couple of her nurse friends had said, "Whatever you do, if your doctor is away, don't let these other guys deliver you. Oh, no, Susan, you can't, you can't let them deliver you!" They were worried about episiotomies ending up "at your kneecaps!" "Butcher types is how they were described," said Susan, "Well, I literally went into a panic. So I brought up my concern about who I would have if he wasn't there. And I was so pleased because he just said, 'If it bothers you I could recommend you to a group of doctors and then you will know everyone.' He sort of gave me the go ahead, so I changed."

One Saturday, not long before Christmas, Susan again brought up this feeling of vulnerability. Paul was away for the weekend skiing. "This weekend it bothers me more than it normally would have. You see, he is gone and I can't get hold of him. I keep thinking, 'This is irrational, he's fine,' Yet I keep thinking, 'Oh dear, this baby needs a father—nothing better happen to him.' But he has always done this and it never bothered me before.

"And I panic a lot, I'm scared walking, slipping on the ice, and driving when it is really snowy. I've always been gutsy, it never bothered me. But now I think, 'Oh dear, what if I slipped off the road, or what if something happened.' I am just more conscious of it. At work they leave a space for me right in front of the door!" Susan had quit carrying out groceries. She had been getting spasms in her side that, at one point, kept her home for two days. She finally nailed down the cause. "I thought back to what I had lifted and realized I had carried some boxes with paper work and things. It wasn't like they were really heavy, but they were probably just straining me. So I quit going for groceries, and I really miss it!" she laughed.

It wasn't until Susan was into her eighth month of pregnancy that she let herself get excited about baby things. Earlier she had said, "It is just too early, like it is going to be jinxed. It is a silly feeling but"—however, now, that she had finished work she felt better about shopping for the baby. "And if worse came to worse and I delivered the baby now, there is a pretty good chance that, you know, things would be okay. Now I am going to sew curtains and make a comforter and that kind of thing."

When Susan talked about the pain she really was concerned that she had not been too noisy and that she had been "good," that is, not "out of control." "I just didn't want to be yelling and it was hard to judge how loud you are." Susan thought the birthing room was very cheerful, with its pretty wallpaper, a rocking chair, a coffee table, telephone and a new birthing bed. It was the first time the bed had been used so the nurses, referring to the pamphlets, had Susan try different positions that could be accomplished with the various attachments on the bed.

"It was such a relief at that point to finally start pushing," Susan admitted. "They thought he'd be out a lot faster but the cervix was not retracting so eventually the doctor decided to use forceps. So he gave me the needles and we got pushing again and I could feel where he was pulling—and there was suddenly a click, and he said, 'Well, you're doing it yourself now.' And the baby was born at a quarter after eleven and then I couldn't believe the sensation because—it was—as soon as I saw him, it was as if everything was gone. It gets very blurry. I guess it was unpleasant for a while. But it was a nice feeling that it was over. It was just mostly feeling him and seeing him. And the forceps marks are totally gone now. But I couldn't believe how blue he was. They tell you in prenatal classes how blue they come out, but he was BLUE .. the little face was kind of purple and the rest was all blue. Paul was somewhat concerned about him, that he wasn't breathing okay, but they all said he was fine.

"I liked not having to be under blaring lights. When he was delivered, it was dark in the room except for a light for the doctor. It was a much softer experience than I expected. And they didn't rush the baby away but they brought him to me right away after they checked him out."

Again I wondered about the pain. "Does the pain of labour have any value?" "I think it was a useful experience," said Susan. "I would go through it again. I have no hesitation about that. And, at the time, I kept thinking that this is for the baby. I learned a lot more about Paul. We both said afterward that it was a love deepening thing. That was one of the nicest things and a very good experience for both of us. I knew I loved him when I got married and I knew I loved him all the time, but I really knew why I loved him after we had this baby. So I think that is one of best things of the whole labour. And I learned about myself. I've gone through other painful situations. I was married before—and for a time I thought this was it—that I couldn't survive anymore. And now I look back at it and realize it was a positive growth situation for me. I look back on myself and can't believe how I used to be."

Anna

Anna and Bill had talked often about taking responsibility for the birth of their child. Their decision to have a home birth was carefully considered weighing all the evidence for safety, as well as what is best to them. We had talked together in their home four or five times, and many times both Anna and Bill discussed their decision for home birth as a decision about responsibility. Bill said, "My sister, who was initially against the idea, is actually envious of us. She admires us for doing it, she thinks it takes courage. But we don't think it is taking courage, it is taking—what it really is—the ultimate in responsibility, that responsibility if something goes wrong. In a hospital there is always someone to attach responsibility or blame to. But if it happens at home, we will have to be responsible." Anna agreed, "I have thought of the potential of—let's say the baby doesn't make it—if it is in the hospital everyone would say that the doctor tried his very best, and if it should happen at home, we are going to be seen as irresponsible, and killers, and murderers. That is pretty drastic and I guess I am willing to live with that. I think we deny death. For how many people is death a real thing? How many have seen a dead person? Or touched a dead person? We have dehumanized death, just as hospitals have dehumanized birth through interventions, and goodness knows what else. I think that for us a birth at home is less of a risk than the hospital. People do not want to believe that it is safer at home because they want to put the responsibility into the hands of the doctor and the hospital. "Of course," she said later, "I would go to hospital if I have to, but I really prefer not to."

So the talk was of responsibility and irresponsibility. Anna is used to taking responsibility for herself, "an adventurer" as she called herself. She described herself as being a rebellious teenager in a minister's family, being the only whites in a community in Western Samoa, taking a 5000 kilometre bicycle trip through Europe, and now, a homebirth.

Bill and Anna are puzzled why so many people who talk in a negative way about their hospital experiences with childbirth still go back to the same situation the next time. Anna stated, "I think it is because men are very protective or else they doubt our capabilities, and maybe that is why they are protective. I think it is all tied up in the man/woman relationship with man trying to be superior to woman and maybe envious of woman's capability to have children. Doctors/obstetricians often want to take credit for the delivery."

I asked Bill what he thinks of Anna's suggestion that men really desire to be able to give birth. "Is that true for you? Do you feel that you would like to have the baby yourself?" But Bill said he does not feel envious. He said, "I know that there is something going on there that I will never, never, know about. I think, sometimes I feel, that there is a bond being established right now that I, as much as I would like to, can't be a part of. Because it is just not possible." He looked to Anna. "But I like, by our closeness, to feel that I get a look, a see. There is always going to be something dear and special about a mother and child relationship, no matter what qualities I bring to it, it is something I can't hope to penetrate. I think that is the protectiveness that a lot of men have toward women." To this Anna reacted, "You see, I don't think that protectiveness is a valid, honest feeling for men to have, for the doctor to have, because, let's face it, women are built for the situation. The body takes care, the body does it all. We don't need episiotomies, we don't need enemas, we don't need to be shaved, the body takes care of it. And yet, man does all those things. The doctor is usually a man."

She continued, "I was thinking and talking to my mother about this. All the preparation for a home birth that we have to undergo is really good for us emotionally, psychologically, and even physically. We are responsible for getting the plastic sheet and sterilizing the towels. It has been good, even if to a certain extent you're overwhelmed with the responsibility. I guess I feel that I wouldn't encounter that responsibility if all you did was to pack your bag and go to the door of the hospital. It is a different kind of preparation.

"It is like immunization," said Anna. "Immunization is controversial. It is not as if we are not going to immunize, or want to be irresponsible. It is just that we are not going to accept something without question or research. We may come to the same conclusion, but at least it is our decision." She feels that generally one gets one's "knuckles rapped" for being skeptical.

She returned to the possibility of problems with the baby at birth. "One of the things you have to think about is if the child doesn't make it, is stillborn or ... I think it would be better to be home, it is the best place to experience that, where you have your friends and your loved ones around with you. Birth and death are on a continuum, I think, and as hard as that would be, I'd prefer to be at home and we have prepared for that.

"And then when she did come out, her face was quite blue. She was limp, had no reflexes, she didn't grimace or sneeze or do any of that kind of stuff. Her heart rate was good, but her respiration was irregular and slow and her colour was blue. She didn't make any noise."

This conversation took place the day after the birth. Anna was speaking about her newborn baby whom she held in her arms. Bill, Carol (her sister), Kate (Carol's eighteen month old daughter), and I were sitting in their home drinking the coffee that they served. Bill continued, "After she had the oxygen she started breathing and sputtering and crying. Her apgar score was only four at one minute. It was pretty scary. The midwife was very calm. She did what she had to do. But after it was all over, the midwife too was shaking."

Anna, in a calm voice, described what happened next, "Jena really recovered well, though. Within about two minutes she began to cry and that was just wonderful. We didn't even know whether she was a boy or girl at that point of time. She was on my tummy."

"It took a while to sort of get over that," said Bill. "I guess I thought that any breathing problems would be more a result of drugs in hospitals so I was really taken aback by all this. And I thought, 'Oh, my gosh, is this what having a kid is like? Terror like this? Will she be okay? Will she be okay tomorrow? Will she be okay the day after?'"

Katherine

We settled down in the living room, with a dish of cut up apples, nuts, and raisins. As I set up my tape recorder, I explained the nature of my study. Katherine was five months pregnant, wearing a maternity dress with tucks and ruffles at the neck. Her animated talk gave me the feeling that this pregnancy was good for her, and that she was enjoying herself. Her home, warm and inviting, displayed Indian hangings and oriental carpets giving a feeling of worldly experience. As we sipped raspberry tea she talked.

"I'm 33 now and up until I was 25 I would have said that I had too many other things to do, and then it seemed to me, that the women that I knew who had children were in a disadvantaged position a lot of the time. As mothers, it seemed that all of a sudden their power or influence had really changed in society generally, as well as their relationships with their husbands."

Katherine had very deliberately chosen a line of work which she could rely on to support herself, and which would offer opportunities, as well as be adaptable to a woman's needs of childcare responsibilities. When she had thought about what kind of studies to take, she looked for the kind of work that would offer the possibility of being in and out of the work setting. "I am not a career woman," she said emphatically, "in that I do not want to live the job, but I want to have a job that will fit into how I want to live." She goes on, "I was beginning to think of being a mother, but as well as being a mother, I wanted to maintain my independence both in this relationship and if this relationship didn't exist, I want still to be able to function on my own, and be able to bring up the kid."

She talked again about her friends who have children. "They were deeply involved in their children which really changed what they wanted to do, and what they were able to do with their lives. I decided that for the next bit of time, say between 20 and 25 I might be physiologically ready to have children, but mentally I was not. I had too many other things to do. I did a lot of travelling and had different jobs, before I went back to school at 26. And I wanted the job to fit into how I want to live so I spent three years in pretty intensive schooling getting a degree which would, hopefully, make it easier for me to do what I wanted."

Katherine's man, Mike, had to be convinced that this was the time to have a baby. He had said to her at one point, "Well, you may be ready, but I am not absolutely ready at this time." So she described the waiting until he felt it was an okay time. She had said to him, "Look, I can't wait forever, I don't mind waiting until you are ready, but please consider my situation. You can go on forever, but I can't! I thought that I should do something about it in the next couple years, or else it is going to get into a much more risky business, and I would prefer not to get into risk because ultimately the way I would like to go about having a baby is via a home birth, to make it as natural as possible." She backed this wish up by saying, "That is because I am not one that really enjoys a lot of interference in what I am doing in my life."

The decision to have a child was, as Katherine said, "a long time brewing." At one time she even thought that she might not want to have children. "But," talking so quietly that I could barely hear, "I just didn't want to say that, 'cause it doesn't even sound nice to say something like that. However it was something I thought about. I was making this decision about me, my body, and my life, and that was the way it was. But between 25 to 27, it was almost a biological thing, a real physical kind of feeling, and I know that sounds kind of hokey, but it was that my periods were something that were making me think, that each month my periods demonstrated that nothing had been done about that. Although I didn't want to do anything about it, I was thinking about it."

Eventually the time was right for her and Mike. "I had a really strong feeling before I missed my period. It was at that particular time in my cycle. It happened to be a particular cycle that we had had lots of good sex, and there was a change in my body, like I knew. I could feel the change in my breasts, a real change, and then I missed my period. That knowing made a difference. We had gone out for dinner and had wine with everybody else, and just because I had that feeling in me, that hunch, then obviously I couldn't, I shouldn't be drinking now. It would be an inappropriate thing to do." She kept the glass of wine in front of her because she did not want anyone to suspect her pregnancy, but she did not drink the wine.

Katherine was so sure of her pregnancy, that in buying the home pregnancy test, she opted for the "one-shot deal," rather than the one that contained two tests. Yet she wanted the doctor to verify it, too. She was nine weeks pregnant before her pregnancy was finally confirmed by the doctor. "It made it feel like, all of a sudden, that the process was really under way, like things that I knew had to be sorted out, that had to be taken care of right away. At that visit, the doctor went over, (with Mike and me), information about nutrition and supplements, about how to do perineal massage, and about breast preparation. I felt that he had looked me over, and that I was okay. I felt I was okay but it was good to hear it from someone else. Now, I knew it was real—like my body was telling me. But it is strange that you can't feel a thing. When you first feel movement that you know is decidedly nothing else but the baby, that is really, like you wait a long time for that confirmation that there is something that operates quite independently. It is just great.

"For a while it seemed that I only felt the baby when I laid down, when I was quiet. Now I can feel it anytime during the day, a lot of different times, but mostly when I lie down, and it is fun to watch my stomach change shape, and it is getting much more vigorous than it was. I haven't been able to isolate a heel or hand or head. I can't tell you where this kid is, I can't sort it out."

Katherine did not have the ultrasound test because there was no reason for it. While she thought it would be interesting, and did not think it would be harmful, she felt that since it had not been tested over a long period of time, and as it is not necessary, she would not have to have it done. She elaborated, "there are things that are meant to sort of be mysteries, that you don't know about, things that you can't be sure about." She was referring to the pre-birth knowledge that some people have about the sex of the child. "It is interesting that I don't want to know. I don't feel that there is a need to know."

Later she said, "I am certainly aware of my pregnancy now. It is difficult not to think about it, because there is a lot of movement, you do have to go to the bathroom quite often, you are hungry, there are all sorts of little things that are saying that you are pregnant. A couple of times I haven't been able to get through a space even if I pull my stomach in. I am just too thick. I can't bend over easy—like putting on shoes. It is neat to have bigger boobs. I never knew what that was like—it is kind of funny! And the clothes. I began to realize that I had to get something. But I was shocked and dismayed. It is not like I am trying to hide my pregnancy but the clothes are huge, just bags—and they have little puffed sleeves. You really have trouble avoiding the bows, and the heavy duty gather, the sort of baby-fying clothes. I just don't want to look like that, to feel like that. In fact my boss, who is well aware that I am not very keen on having clothes that look 'the part,' said, 'Now don't you look sweet!' Teasing me because she knew I didn't like it."

Katherine talked about her decision to have a home birth. She said, "I really think of the home birth as a continuity in the way I live, that having my baby at home just makes sense. It seems to me that if you do believe birth is a natural process then it can happen easier at home more naturally. It seems to make the whole thing more true." Her family questioned her about it. Her brother, a doctor, suggested to her that some people are electing Cesareans when there is no "real" (that is, medical) reason. She said, "I thought that was illegal. The way he put it was that this child was a very special bundle and this colleague didn't want to take any chances on a vaginal delivery and opted for a Cesarean. He said there is not that much morbidity associated with a Cesarean now. He made it sound like these colleagues of his perhaps valued their child more!" According to Katherine, "that is the ultimate in the medicalization, the technological kind of thing that really doesn't look at the whole picture—really a sad case."

In the talk about Cesarean births, Katherine relayed the situation of a friend who had two children by Cesarean section and was told that one does not really know what birth is like unless you have a vaginal birth. Katherine said, "I think that is a lot of hogwash because I know the relationship between you and your child starts with your pregnancy. A Cesarean is kind of an interruption in that but I am sure that you can establish as good if not better relationship with your child, mother/child kind of thing, afterwards. It doesn't depend, I don't think, on a vaginal birth."

The baby was born by Cesarean after Katherine been in labour for a couple of days. Her membranes had ruptured yet her cervix had only dilated four centimeters. The surgery took place one stormy night a few days before Christmas. "And then when I was back in the room in the bed and people were attending me, cleaning up, taking blood pressure, and all this fuss and bother, Mike came in to see me and Mike told me that we'd had a girl and that she was eight pounds ten ounces and I remembered that I had been told, but it hadn't registered. Mike said, 'You can see the baby if you want,' and I said, 'I can't.' I just didn't have the energy." At that point it was hard enough to focus on Mike and respond to him. "He was leaning over the bed and beaming and said that she was lovely and that everything was fine and she was under a lamp to keep warm."

Katherine did not see Brett until the next morning. "When I first saw her, and the nursery nurse was a little bit concerned about leaving this baby with me, because I was a Cesarean, she double-checked and double-checked the tags. . . . I was waiting for this lady to go away so I could grab this baby and have a look at her.

Later she said, "When I first saw her I was really surprised at what she looked like—I didn't know what to expect—I guess I expected a fair child, she is dark; and I didn't expect such a big baby. Her face and her big chubby cheeks were really a surprise. I think that probably the real feeling [of mothering] happened over that first day. At first I think I was just too curious. I just looked at her as an object to examine and see all that is there, but then after a while, just being able to comfort her. That is, if I talked to her she seemed to be soothed. She seemed to know somebody was there. When you get a response from the child to something that you're doing, that feels motherly then. Maybe that is when you start feeling it.

"I pricked Brett with a pin a couple of days ago," confessed Katherine when the baby was about two months old. "It was terrible. I was morose the whole afternoon. I felt so bad!" It took Brett a while to react and for Katherine to realize what had happened. "She went to sleep when she finally did settle down exhausted from crying, and I couldn't wait for her to wake up again so I could hold her and say, 'It's okay, I'm sorry.'"

We talked about the Cesarean. "When I think about the Cesarean I wonder 'why?'—why it went that way—what was I doing or what was I not doing? Again it is kind of a guilt thing. As I say, I've apologized to her I don't know how many times—'I'm sorry kid, that it happened like that.' I am trying to find out more about it from John [the doctor]. I want to know what the obstetrician wrote. I want to know why it was necessary to do it. I want to know her Apgar score. Perhaps there is a little bit of sadness that it happened that way, and there is a real sense, when you have a Cesarean, of the inadequacy of your body. It didn't work right!"

Then Katherine told of the sense of uncomfortableness around people who knew she had planned things differently. She said, "One of the girls said to me, 'Could I be frank with you? I don't know what to say to somebody when they've had a Cesarean birth. Do you say too bad or congratulations or what?' And I said, 'You can say congratulations about the baby, but it is too bad that you had to have a Cesarean.' As far as I am concerned, it is too bad, but that is the way it went and it is too bad."

I wondered how things have changed for Katherine. She said, "I've got Brett on my mind all the time—whatever I am planning to do. It's on-going. It's fragmented my thinking. For example, if I am watching the news and she is awake, I can't pay really good attention—or when I am on the phone. If she needs me for whatever reason, or if I am aware of her, other things have to go. I guess I think that mothers live a very fragmented existence."

She talks of going back to work in the Fall. In addition to thinking about the childcare arrangements and how she will work and still spend enough time with her baby, she also wonders how having a baby will affect her work. "Although I am not very career minded, I find that when I have special a project going I become quite involved with it. I don't know whether or not some of the ways I've responded to things at work might change because I have a baby at home who has more priority than the job." Yet she wondered, "You never get paid in money—that is with any official recognition—for what you do as a mother. And you do a lot. I don't want to think of it like 'work' because it is all tied up in loving your baby, loving and caring for your baby. Perhaps there has got to be enough intrinsic reinforcement of what you are doing or things may just get out of focus. I can't feel too strongly about that right now, but I sure can see how it might happen, that you start feeling, 'Why did I buy into this one?'"

Women Speak of Change

> Through you, Ariel, I'm enlarged, connected to something larger than myself. Like falling in love, like ideological conversion, the connection makes me *feel* my existence. (Chesler, 1979, p. 246)

There are mysteries surrounding the transformation of woman to mother which we cannot, and, perhaps should not, try to articulate. It is necessary, rather, to treasure the mystery while we try to grasp what can be revealed. Becoming a mother involves a movement from one mode of living to another; from woman without child to woman with child. That is straightforward, no mystery there. But attention to the "movement" itself, the movement from one form of life to another, may reveal elements of transformation which are contained within mystery.

> Woman necessarily experienced herself as subject and object of mysterious processes and as a vessel of transformation. The mysterious occurrences in her body, the instinctual mysteries of her existence, are exclusively the possession of woman [womankind]. (Neumann, 1955, p. 291)

The changes that occur in a woman as she births a child—that connection to a reality larger than oneself—is a connection that is felt through living as mother. On the one hand, in recognizing the mystery and awe of giving birthing and becoming a mother, there is the inherent danger of seeing the activity of reproduction as the "major identifying characteristic of female human beings, and indeed our primary reason for existing," which Morgan (1984, p. 41) argued can lead to disregarding women's "authentic human rights and powers." On the other hand, acknowledging and accepting the mystery can remind women of the magnitude and sacredness that being a mother entails—as bringers of life to children and to society.

The experience of childbirth ties women to the fundamental cycle of life: birth, death, and re-birth. I remember very poignantly the death of my father at the time when my daughter was three months old. Her coming (her presence) helped to bear the pain of his going (his absence). My being a mother assured that life would go on. "The old cycle repeats itself again and again. . . . Nature goes on repeating itself but there is no end to its infinite variety and every spring is a resurrection, every new birth a new beginning . . . it becomes a revival of ourselves and our old hopes centre round it ..." (Sorel, 1984, p. 27).[1] But "becoming a mother," is more than a revival of ourselves, that is, a living on through our children. Becoming a mother shows, perhaps, the possibility of renewed life through birth, not only of our children but of ourselves. Is it possible that as a woman becomes a mother she can become truly herself?

What then is the nature of the transformative experience of *becoming* a mother? How does the birth of a child offer a woman the possibility of new life? We see that women move to motherhood in a linear way, through the nine month pregnancy, the twelve hour labour, the forty-five second contraction, the slow passage of the baby through the birth canal, the timeless wait of first breath, and the momentous reaching to take the baby in one's arms. But on another level, this movement is not linear. A linear view does not account for the intertwining of the growing, accommodating, and birthing woman's body and her developing relationship with the child she carries within and to whom she extends her arms at birth. A linear view does not accommodate the depth of change that such a transformative process entails. New experiences reach back to earlier experiences which are now understood in a different modality. Similarly, experiences earlier in the pregnancy reach forward to envelop present experiences with transformed significance. These transformations take linear time but involve change that is deep, complex, and dramatic. Thus, the move from woman to mother can be profound, and may, as Neumann (1955, p. 32) suggests,

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[1] These are the words of Jawaharlal Nehru in a letter written from prison in 1944 at the time of the birth of Indiri Gandhi's first child, Nehru's grandson, Rajiv.

"reshape the woman's life down to its very depths." "Having a child drastically changes the lives of most women, opening up previously unimagined new selves, new areas of responsibility, delight, exhaustion, anxiety, ambivalence, and physiological change" (Morgan, 1984, p. 223).

Women expect to be different as mothers. In fact, they are continually reminded by everyone that their lives will never be the same again. They will never have a night's sleep, never be able to go to movies, never be free to live their own lives. In pregnancy women worry about this change. They wonder about their changing relationships with the men and women in their lives—their friends—their own mothers. They begin to feel their dependence and vulnerability. They wonder about their ability and their energy. They fear that their bodies will age and sag. They wonder if they will be ready when their "time" comes. They even wonder if they will love their child. Yet, as they express these fears they also expect change as Jane said, "I never really liked children, but everyone assures me that you will like your own" (J1).

The Transformative Moments

Brenda's experience of her impending motherhood places the concept of transformation into questioning relief. *What is meant by transformation?* Did Brenda enter a transformative experience? Was she open to the experience so that her life was changed? How can we begin to open up the phenomenon of transformation of woman to mother? What is the nature of transformation? Brenda was inhabited by a child before she seemed ready. When her baby girl was born she could not immediately accept her. Earlier in pregnancy she said that she should be exactly as she was before, "I want my own life too, like if I want to go out for an evening with my friends, I should be able to" (B1). Even before pregnancy she and her husband decided that they should not change their whole life because of a child. "We should change some things, yes, but you have to be yourself or you—would be at each other's throat. It would be more of a chore than a blessing" (B1). Brenda had wanted a boy. It took her some time to accept her baby girl. Almost a week after the birth she admitted to still calling her baby "Kevin," and referring to "her" as "him" (B3). She said that Tom, her husband, tells her she is a terrible mother. "But, it just doesn't want to go through my head that she's ours and she's a girl and not a 'Kevin.'" Then she looked at her baby and said, "But we'll keep you, right?" Two months later Brenda still is aware that the change that is expected of her is slow in coming. She said, "I don't talk about Suzie unless I'm asked. A lot of people are upset because I don't carry a picture of her around. And a lot of people get upset because I call her a "kid." But I'm not going to change overnight" (B4). But then, eight months later, she could say to her pregnant friends who were worried about becoming mothers, "You change, just give it time, it will come. Before it was, 'I want to be a mother but I want to be myself.' Now I figure that I am myself and I am a mommy" (B5).

It seems possible that the transformation from woman to mother is suspended for some women, taking longer for them than for others, varying in intensity and depth. For Brenda, although she could not deny the reality of pregnancy, she said, "I don't want to be a mom just like that" (B1). Neither could she deny the reality of the child born to her, yet she said "no" at the time of birth (B3). How many women say "no" at different points in their own experience, and feel ambivalent about the magnitude of change in their lives? Is it possible that some women always say no? It is possible that they cling to their familiar life because of fear? Or refuse to make the necessary sacrifices that come with having children? Are there some women who are unable to receive new life, either for the child or for themselves?

Brenda's talk is quite different than Phyllis Chesler (1979) in her book *With Child*. Phyllis said to her child:

> Last year I died. My life without you ended. Our life together—only nine months!—ended too: abruptly and forever, when you gave birth to me. Being born into motherhood is the sharpest pain I've ever known. I'm a newborn mother, your age exactly, one year old today. (p. 281).

Here the language of transformation is dramatic. The woman died when the mother was born. The pregnant woman was transformed too: the symbiotic togetherness ended. The separation was painful—a sharp pain. An Abyssinian woman reminds us of the extent of the impact this transformation has for women:

> The woman conceives. As a mother she is another person than the woman without child . . . . Something grows into her life that never departs from it. She is a mother. She is and remains a mother even though her child dies, though all her children die. For she at one time carried the child under her heart. (Meltzer, 1981, p. 3)

To become a mother is a change which may be more complex and overwhelming than any other social transition which involves upheaval and change. It changes one's life forever.

The present intensive exploration of a woman's transformation to mother is confined to a short period in women's lives—over the period of pregnancy and the first few months of caring for the child. This does not mean that the process of transformation is a succinct experience. Rather transformation may be a never ending process, changing and developing each moment in the lives of women with children of varying ages—in the womb, infant, school age, adolescent, or adult. "In a very immediate and day to day way women live change," said Miller (1976, p. 54), they change with their growing and developing children. Gaining a better understanding of this dynamic process which occurs in women who mother can give clues to understanding a learning experience appropriate for all people living in a rapidly changing atmosphere of the present age. Such a learning process might uphold "growing" as opposed to "aging"—if we just learn how (Ruddick, 1983, p. 219). Yet the intense period of pregnancy and birth is a time of deep change, as Chesler (1979, p. 164) so vividly exclaimed, "Women, Do you think I'm not drowning in this transformation to mother?" Or as another mother said, "My daughter has changed part of my understanding so radically that I have difficulty recognizing who I was before" (Dowrick & Grundberg, p. 79). Susan, too, said, "I look back on myself and can't recognize how I used to be" (S4).

Wherein does this transformation reside? Where does transformation begin? Is there a beginning? One way of conceptualizing the beginning of transformation from woman to mother is to examine the experiential situations and relations that are involved in the decision to have a child. Deciding on a child may change a woman's life. With Christine we are confronted by the decision or the resolve to have a baby. ***What is the nature of the experience of decision?*** Is the resolve and the planning that ensues from it already a significant element of the transformation? Was Christine's resolve a real commitment? Christine said "yes" to a child in her life but when the child did come—and there was the possibility of miscarriage—Christine's managerial decision to have a child was questioned in a different light. How does the resolve to have a child transform?

Transformation to mother, for Jane, seems to focus on the presence of the child. ***How is the presence of the child experienced?*** It was through seeing and knowing the child and her changing body that Jane began to know herself as a mother. Through the interrelatedness with the child in pregnancy, at birth, and in the care, a woman begins to see herself as a woman who is mother. How does the interaction with the child transform a woman to motherhood?

Birth is a separation of mother and baby. Susan's story is suggestive of the paradox of separation that brings integration and wholeness into her life. ***What is the nature of separation that leads to integration?*** What part does a woman's reproductive labour play in this move to wholeness? What is the possibility of pain in this transformation? How is birthing pain experienced?

Next comes Anna's story. Anna showed that with decision, pregnancy and birth comes responsibility. How is responsibility experienced? To decide to be responsive in a deep sense to life with children is to be open to its terror and possibilities. But does Anna realize this aspect of responsibility until she is transformed through life experience? ***What is the nature of taking on the responsibility of motherhood?*** What is it like to take responsibility that terrorizes one? What is it like to be responsible for that which is beyond control?

Katherine's story brings into focus that transformation to motherhood involves a self-questioning and a disruption of previously held self-assuredness. She talks of self-guilt, of wondering how she will be competent now that this child is on her mind. She is even rushed home by thoughts of her child. ***What is the experience of having a child on one's mind?*** Is there the possibility of the losing of self in the move to motherhood? How can one lose oneself to another, and yet be oneself?

These moments will be used to bring to light aspects of the transformative experience of childbirth. The complex pattern of movement from woman to mother shows itself in the development of each moment. In a sense, each individual thematic moment reveals the transformative process, not fragmenting the process into different stages, rather each moment is an example of one way to look at the process. At the same time, however, all the moments together uncover more clearly the whole picture. I think of a small crystal which sits on my desk. As I look through the crystal head-on there are dark spots through which I cannot see. In order to see more clearly the crystal must be turned a bit, to allow me to see well from that one angle. Again, I must turn the crystal to bring to light another point if view. So it is with the thematic moments of the transformative experience into motherhood. While overlapping, each moment views the process from slightly different perspective, bringing aspects into focus which could not be previously seen. Yet, at the same time each moment casts its shadow and its reflection of the other moments.

Throughout the exploration, the existential themes of time, space, body, and relationship will provide a structure into which the story moments are woven in order to describe the fundamental experience of women as they experience the birth of their first child. The attempt is to weave the threads of these themes and moments into an experiential fabric which describes the transformative process of woman to mother. Such a weaving will produce a work that will have its own design, dependent on the colors and textures of the materials, and the inspiration and skill of the weaver. Although the pattern is individual, in a sense a creative work, the whole will show a possible human experience,—a possibility of coming to an understanding of women's transformation to mother. The phenomenological approach used here is not immune to critique. It simply is the best way I know at present to construct a narrative that through its mimetic textual quality allows us to return to experience in an enriched fashion. The next five chapters take a closer look at the transformative process through exploration of transformative moments:

Chapter 4	What is the nature of the experience of decision?
Chapter 5	How is the presence of the child experienced?
Chapter 6	What is the nature of separation that leads to integration?
Chapter 7	What is the nature of taking on the responsibility of motherhood?
Chapter 8	What is the experience of having a child on one's mind?

Chapter 4

SEARCHING FOR THE BEGINNING OF WOMAN AS MOTHER: THE TRANSFORMATIVE EXPERIENCE OF THE DECISION

The Meaning of Decision

"The deep personal significance of the decision of whether or not to have children [is] the most irrevocable and important one that most of us will make" (Dowrick & Grundberg, 1980, p. 8). Christine (and her husband) made the decision "yes, we will have a child" with thought and care. But as she reflects on her resolution Christine also senses her own indeterminacy about the meaning of the decision. She said:

> You think about it. You *think* you want to be a parent. You *think* that it will be a neat thing. You *think* it will give you the positive feedback that a career can give. But you don't know. You have to find out. (C7)

A woman decides on motherhood. What does it mean to understand such a decision as decision?

In a pamphlet "Having a Child . . . Is it for Us?" made available by the Planned Parenthood Association, the seriousness of the decision to have a child is emphasized. Such a decision "deserves to be arrived at only after a careful look at the adjustments that must be made." One is encouraged to ask oneself questions like: "Does having and raising a child fit in the life I want to live?"; "What can I get out of it?"; "What is there to know about kids?" These questions relate to one's job, goals, energy, leisure-time, finances, and priorities. One is encouraged to explore one's reasons for wanting a child: "To give someone the opportunities I never had?"; "To have a child to be like me?"; "To keep me company?"; "To pass on beliefs, values, and ideas to?"; "To prove my femininity?" One is encouraged to ask oneself: "Do I enjoy being with kids?"; "Do I like teaching?"; "How do I handle angry feelings?"; or "How do I feel about getting up at night?".

The problem of decision-making about motherhood is very real for women in present day society (Fabe & Wikler, 1979). In the past, there may not have been a "real" decision, maybe one just accepted (or rejected) what nature (God) brought. Of course, women, in earlier times, did make decisions about children, as evidenced by the number of "back-room" abortions, or the fluctuations of birth rates during differing economic and social circumstances. Contraception has made decision-making openly necessary, forcing women, as never before, to respond to the question of children in their lives. Some women try to ignore it; some put it off until it is too late; and others panic and end up with the "symbolic child" (the child that is conceived because of fear that life is passing by rather than because of a desire for a child). Some live to regret what might have been—to regret the personal disappointment of being childless (Greer, 1984).

Fabe & Wikler (1979, p. 263) said that the most important question to be dealt with in the decision of whether or not to have a child is "How much do I really want a child?" This question should be confronted head-on. Psychotherapy, couple therapy, getting more exposure to children, and insights gleaned from imagination of life with children, are tools which may assist in facing this question. But how can one know what it means to have a child before one has a child? How can one even know what it means to want a child?

The question of wanting a child reveals an important dilemma. Many women who have children speak, like Chesler (1979), of the profound, and deep, transforming experience. They discover commitments of which they did not know themselves capable. They find a happiness they never dreamed possible—like the woman who thought being a mother would be stultifying yet found it "exotic." Of this knowledge the childless woman is totally ignorant. She cannot know. To ask: "How much do I really want a child?" is to really ask, "How much do I desire a new responsibility which may commit me in a way I cannot now possibly fathom?"

The women talked about their decision to have a child. They said:

> I think there is something called the nesting syndrome. It just hits people. Many who said they would never settle down, never have kids, all of a sudden at 29 or 30 seem to want to settle. (J1)

> It was always a consideration, just a matter of when. A lot of things came into the consideration— finances, job security, the fact that we love to travel, the question of bringing a child into *this* world—being torn between those things and thinking that we would be good parents and me desperately wanting to be a mother. I know it is right—I think there is a yearning for a woman to be a mother. (A1)

> It was always sooner or later. We have been married five years, we have our house, have our dogs, have our vehicles, it is more or less time. (B1)

> Really it is a biological thing, a real kind of physical feeling. My periods were something that were making me think—each month my periods demonstrated that nothing had been done about that . . .. It was something that suddenly became a strong basic urge. (K1)

> We talked about it. Yes, we wanted to have children. However, then when we decided to have a child, it was a different story. Then we had problems getting pregnant. (S1)

There are considerations, such as the yearning, wanting to settle, or developing a nesting syndrome; there are considerations of "having a house," and the reality of the physiology of getting pregnant. Do these notions speak to the question of "How much do I want a child?" To yearn has a sense of longing for something that needs fulfillment, as if a woman without a child is unfulfilled. Does having a child fulfill? Does a child help one settle? Does "having a house" allow one to think about children? What if the child does not come? Will one then want a child more? And what about the child who comes when the woman does not want a child at all?

Think back to Christine's story. Christine handled her decision-making very deliberately. She wanted a child enough to stop using contraception. She became pregnant just as she had planned. It was a rational decision. Or was it? She started to bleed. There was a chance she would lose the child. She had experienced, in some way, the presence of the child—so that now the thought of not having a child took on a different meaning for her. It almost seemed as if the child was deliberating about her as well. Having experienced the child's presence, Christine experienced the absence. She could no longer think of her life without a child. The very circumstance of conception changed her life forever. All her previous rational deliberations lose their relevance—she is caught by life, so to speak. She was captured by the very presence of the child.

Let us listen to two other voices. Judy Chicago, a woman who is dedicated to articulating the experience of women in birth through her art, does not have a child. She said, "I have almost never really allowed myself to need another person, to depend upon another person. I've always deprived myself of that so as not to get 'caught.' But I understand how one can be caught by life. It is something most women seem to both crave and fear" (1985, p. 34). Oriano Fallaci, who became pregnant by mistake, said:

> I am locked in fear. I am lost in it. It is not fear of others. I don't care about others. It is not fear of God. I do not believe in God. It is not fear of pain. I have no fear of pain. It is fear of you, of the circumstance that wrenched you out of nothingness to attach yourself to my body. (1975, p. 9)

Both women want to "make it alone." They do not need others. They do not need the "Other," in this case, the child. Does Chicago truly realize the deep truth of her deprivation—of not allowing herself to need another? Does Fallaci really stand so alone in the world? By the very fact of pregnancy, in the fear of the child, does not Fallaci display her deep fear of (and therefore belief in) the Other, pain, and God? Chicago and Fallaci, in "making" a decision against children do so with a sense of clarity that is eroded with the subtle notion that such clarity may also be a false clarity. Something else is at stake—the circumstance that attached the baby to one's body—the sacredness—the being "caught by life."

Fallaci, Chicago, as well as the other voices that talk of settling, and yearning, are not animated by the deep knowledge of what it is like to have children in one's life. But they are suggestive of the possibility of something beyond the rational "making up of one's mind." The voices suggest the possibility of change in one's life that could be good, overwhelming, and, yes, fearful. There is a "searching for life" in the quality of the talk.

The Latin origin of the word "to decide" comes from *decīdere* meaning "to cut off," which contains the sense of cutting off possibilities with decision-making. On the one hand, we see the decision to have a child as one that will cut off possibilities in life—of "being gobbled up," being "bogged down," "losing oneself," "putting one's relationships in jeopardy," or "being dependent." On the other hand, there is something else at stake, the other possibility of living with a child—as an opening up, a being enriched, which could be a blessing.

> "Are you sorry you did it?" she asks. Intelligently. Urgently.
>
> "Yes," I answer. "I'm trapped." I can't take Ariel back, or move away from him.
>
> A long silence.
>
> "No," I say, "I'm blessed now."
>
> (Chesler, 1979, p. 182)

When mothers speak about motherhood they may be ambivalent. Perhaps this is due to the paradox which takes decision-making about children beyond the rational. "No wonder women don't hear what mothers say until afterward, when they hear themselves speaking as mothers" (Chesler, 1979, p. 182). So instead of the deliberate, rational "making" of decision, "the thinking about it," which sounds like a technical process or instrumental thinking, (supported by the mechanism of decision-making—a cost-benefit analysis), there is a notion of "coming to" decision. Such a notion is, in a sense, like Kierkegaard's "leap of faith"—a realization that having a child opens one to life's possibilities—which can only be taken with "fear and trembling" (Olson, 1986). Such a decision cannot be fully understood until the child is concretely in one's life.

The Time of Decision

It seemed that Christine and her husband came to the decision when the counsellor mediated their tension enough for "the situation to resolve itself." Yet later, Christine recognized that she had, in her heart, already opened herself to the thought of a child in her life but decided that if her husband did not agree she would continue to say "no" to a child. Although she wanted to have a career and had spent many years developing that, the possibility of children was always there. So it may be that the decision for the child was already made—the deliberation came later. It appeared to be different for Nathan. For him a child could wreck everything—the good life that he and Christine had. Christine thought it was the difference in their family backgrounds. She describes what she said was an excellent childhood:

> I saw in my parents that having children had been a good thing in their lives—had really fulfilled them. I had happy relationships all through my childhood, so I didn't see having children as a negative thing—just a matter of the right time. (C1)

So for Christine, the decision was not whether or not she wanted children, but was, rather, whether or not the two of them wanted children. In fact, she said later, that if they had decided against children, she would have grieved for the children she would not have. She was open to children in a way that Nathan was not.

Jane and Brenda, on the other hand, were not as open to children as their husbands were. For Brenda it was much too soon, a shock, "Here I am going to be a mom and I don't want to be a mom just like that. Thank God, it takes five or six months before you really start to show" (B1). Until the baby starts to show itself to others, a woman can deny it to herself. While one obviously, at one level, said "yes" to a child, there are times when the very decision is questioned. Jane, already six months pregnant, experiences times when she doubts about whether she wants to be a mother, "I'm not sure I want to give up my freedom .. and I don't really like kids" (J1). Recall Jane's description of the incident at the restaurant where she worked. She said, "I took the baby, which I would never do in my life, because I don't like kids and I don't like dirty kids" (J1). Moved by that experience in a way that surprised her, Jane, through her own pregnancy, felt herself opening her life to other people's children and to the possibility of a child of her own.

It may not be possible to pinpoint the moment of decision, if there is even such a moment. The decision may come when a woman is "up against the clock," who like Christine may say she does not want to reach 36 or 37 and find out the decision has already been made (Fabe & Wikler, 1979; Russell & Fitzgibbons, 1982). For another, the decision may have begun, in the back of her mind, when as a girl she played dolls with her friends, as a young woman menstruating for the first time, or as an adult imagining a child at her breast, or reaching to take a sweet-smelling baby from a friend. Yet, for another, like Katherine, it may not truly come until she takes her own baby into her arms, and begins care on a daily basis, "when the baby seemed to be soothed by the sound of her voice" (K3). And still, the decision may not be fully realized until the child is sick and the woman is overwhelmed with a sense of what it would mean to lose this child. Then again, it may begin at all these times, experienced by feeling the urge to hold, to stroke, and to nurture the child, with increasing depth and commitment at various times in a woman's life. Of course, there is the reality, too, that a decision may never be fully accepted at all.

Embodied Decision

Time is running on—relentlessly. Thirty seems to be the magic number these days. That is, if women have not had a child before thirty some feel that time is beginning to run out. "Once I came to thirty, there was a sense of urgency," said Christine (C1). "I am 33 and my biological clock is running out. It starts becoming a risky business," felt Katherine (K1). "We are getting older, I'm 31 and Paul is 34," Susan (S1) acknowledged. "While I don't want to be too young either, you know, the maturity factor, but," said Anna (A1), "I still don't want to be a grandparent either." Even Brenda, at 26, felt that if she was going to have two children, she should do so before she reached thirty. She said this in spite of her awareness that the available technology reduces the problems associated with late first-time pregnancies (Fabe & Wikler, 1979, pp. 279-288). The other women, aged between 29 and 33, agreed.

It was Katherine (K1) who said that each month her menstrual period demonstrated to her that nothing had been done about her decision to have a baby. The monthly rhythm of her female body, her woman's body, her bleeding, reminded her that time was passing. Susan (S1) was constantly thinking, "Maybe this month!" The rhythm of women's bodies forces women to wonder about the time for having children. They are forced to attend to the question of the "right" time. In the recognition that the decision to have a child is, for women, a bodily one, Katherine's reaction to her own menstrual bleeding becomes more understandable.

Menstrual blood is the sign of hope and the promise of children. Neumann (1955) in discussing the archetypal[1] nature of the feminine, refers to the mysteries of transformation as primarily blood-transformation mysteries which lead women to experience their own creativity. Menstruation is the first blood-transformation mystery in women—in every respect more significant than the first emission of sperm by the man—and rightly regarded as an important moment in the life of the female (Neumann, 1955, p. 31). The blood of menstruation is truly the blood of life: One wonders why it is so often thought of as "the curse." Perhaps it is that aspects of body, especially the bodily experiences of women, are often regarded as taboo in this society. Think of how information about menstruation is predominantly seen in terms of protection, cleanliness, and effort to carry on with "normal" activities. In fact, the underlying effort is that no one will suspect that a woman is menstruating. Yet, menstruation, while reminding Katherine that nothing has be done about her decision to have a child, is also the outward sign of the potential for children and the continuance of life.

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[1] The meaning of archetype is derived from Greek *archē*, "first," and *typos*, "pattern," "stamp," or "mold," and defined as the original models from which things are formed. It is used in psychology as "patterns thought and imagery that emerge from a collective unconscious of humankind," and in literature as "*primordial images* or *archetypal symbols*" found in recurring myths (Peter Angelus, 1981, *Dictionary of Philosophy*, New York: Barnes and Noble Books, p. 17). The archetypal symbolism referred to here is used to explore the experiences of the women.

The Space of Decision

World as a Place for Children

Does one want to continue this world? The question of bringing a child into *this* world was a factor to be considered in the decision for both Anna and Jane. This world of nuclear shadows, of poverty, of sadness, causes women to feel fear. Yet for the women and men who decide to become parents, it seems that the world, as a space for children, is seen differently than before. "There was a general feeling among people that I grew up with," said Jim, Jane's husband, "that it wasn't a very good world into which to bring a child. But you change, just all of a sudden, and I don't remember it actually happening, the flipping . . . it is more of an understanding of what it is all about" (J1). Is this what Jane called it the nesting syndrome? What makes people want to "settle?"

In exploring this attitudinal flip/flop, this changed attitude toward the world that makes it possible to choose to have a child, I was attracted by Bachelard's image of nests. He said:

> A nest . . . is a precarious thing, and yet it sets us to *daydreaming of security*. . . . And so when we examine a nest, we place ourselves at the origin of confidence in the world, we receive a beginning confidence, an urge toward cosmic confidence. Would a bird build its nest if it did not have its instinct for confidence in the world?. . . The nest . . . know[s] confidence in the world? . . . The nest . . . knows nothing of the hostility of the world. (1969, p. 102, 103)

The image of the world as a "nest" calms our fears. In the act of conceiving a child (into the "nest" of the womb) we show confidence in the world as a good place to be, and we are tuned to it in a new way. The changed attitude may, thus, come first. We see the world as a world for children and are prepared to conceive a child. Or it may be the converse: In deciding on children we come to accept the world as a place for children, take responsibility for the world in a different way.

Chesler (1979) said that when we choose the existence of a child, in spite of what we know about the world, we accept our own existence. Through acceptance of our own existence, which comes with maturity, we come to realize "what it is all about," and sense a changed responsibility for the world. According to Arendt (1961) this acceptance of responsibility for the world and for ourselves is the essential condition needed for people to become parents, the right to "summon" children into life through conception and birth. In accepting a child in our life, we are compelled to face our world in a new way, and to take responsibility for it. Jane's husband, describing his changing view of the world, described the following scenario. "A woman comes up to the bar, obviously pregnant, and orders a zombie, or something else with a lot of liquor in it. What does a bartender do (J1)?" It became a moral issue for him, an issue that has him taking responsibility for the world in a way that he did not before he decided to bring his own child into the world.

A House for a Child

It was in the women's homes where we talked about becoming mothers. All the women worked outside of the home during the early months and all but two of the conversations took place in their homes. With Christine, we met in her office on two occasions, but it was *her* office, with the door closed, and with the request to "hold" calls. It was not a public place. Does it suit the nature of the talk that it should be done at home? Could it not have been done in a restaurant? Or a mall? Yet, the private space of home seems the best place to talk about "motherhood." It is to this house that we bring the child. What is so necessary about a house as a place to talk of childbearing and mothering? What is so important about the house?

Brenda said, "We have our house, our vehicles, our dogs, so it is more or less time" (B1). On first thought, this may seem like a materialistic and inappropriate approach in the consideration of bringing a child into one's life. But what is really being said? What does having a house have to do with having a child? Bachelard likened the house to a cradle. "Life begins well, it begins enclosed, protected, all warm in the bosom of a house" (1969, p. 7). The house has the power to integrate thoughts, memories, and one's dreams. The house is the environment where we participate in the original warmth, a "well-tempered matter of the material paradise." The house holds childhood, maternally "in its arms." Having "our house" gives security to women, a place of protection and confidence. It is now the right time to think of a child. But what does it mean to have a house? And what does having a house have to do with making a decision about children?

House as Home

We have all experienced coming home after a days work in the outside world—or shopping—or travelling. Have we not often heard, "the best thing about going away is coming home?" I remember, as a child, how my brothers and I, as we neared our hometown, would crane our necks to be first to yell out, "I see the water-tower!" And remember the feeling of seeing "our" house as we turn the corner of our street? "Home" takes on a special loveliness when returning after a long absence. It always looks more beautiful than I expect, the hardwood floors covered with the rugs made by my husband's grandmother, my oak table, the tea cozy that brings warm thoughts of shared times with friends, our bed that allows sleep to come more easily. Even the carelessly thrown books, and boots of the children are less troublesome than usual. I am "at home" here. This place is my shelter, my dwelling place. Here, I can be myself. When we have a home, we can think of having a child.

Carrying a child, Anna searched for a new place to live. For her, an apartment was no longer appropriate, for she was planning a home birth. "Simply because of the neighbors," she said, "It would be an intrusion to them, our sounds imposed on them, whether the baby's cry, or, God knows, I'm a screamer, and who knows what is going to happen when I give birth" (A1). But maybe there is more to it than noise. Images of houses are stabilizing and by living in such images, there is space to think about a new life, a life that would be our own, that would belong to us in our very depths. It may also have to do with the need for privacy of intimate and personal events.

The Communality of Decision

A decision without action is not truly a decision. With the decision to have a child, action involved the discontinuance of birth control methods—stopping the pill, removing of the IUD, "forgetting" to put in the diaphragm. For some, like Christine, it meant charting her temperature to identify the day of ovulation, and the most promising time of conception. In all situations, deciding on a child includes heterosexual intercourse (or artificial insemination)—a relational activity. For Katherine it involved "good sex."

Good Sex

"I became conscious of the time in my cycle which was the better time for things to happen. It happened to be a time when we had lots of good sex," said Katherine (K1). Is there something special about the love making when it contains the possibility of conception? We know that sexuality encompasses the processes of childbearing, birth, and commitment to the baby and need not be reduced just to coitus, but that may be easy to forget. With the pleasures of sexual intercourse without the fear or possibility of pregnancy (due to the increasing use of birth control methods), the procreative potentiality of "good sex" may be forgotten. Yet many women remember the moment of conception. What does "good sex" have to do with coming to decision? The sexual act can overwhelm us, putting us in touch with a larger nature sensed by the merger and disruption of our discrete existence (Kittay, 1984). Childbirth is still more powerful, at least for women who are willing, awake, and not terrorized by fear. "The uterine contractions that are needed to expel the baby are far more intense than orgasmic contractions; and the tiny head emerging from within us remains a magical conjuring act which discloses our continuity amid discreteness as completely as any sexual encounter" (Kittay, 1983, p. 118). "Good sex" or "having a go" as Anna put it, with the purpose of willing procreation, ties women's sexual nature very concretely to childbearing. The possibility of childbirth, itself, as a sexual experience, an orgasmic experience, is a real one. Of course, conception can also be a "mistake." But many women, even then, remember the time—perhaps it was an especially passionate encounter—as being together after a long absence—when birth control methods are forgotten or neglected. It may be completely "wrong" at first, so the decision to have the child is made following conception rather than before. For the woman, already on the road to motherhood, it may be extremely difficult. This happened to Paula—and now that Joanna is over three years—Paula cannot imagine what life would be like without her (P3).

We begin to see the problem of trying to separate into discrete themes a process that can not be broken down into fragments. A discussion of "good sex" is as much a part of the decision to have a child as it is to the whole experience of pregnancy, and the birth, itself. Good sex, conception, pregnancy, and childbirth are all part of a woman's sexual nature, and are integral to the transformative process. Becoming a mother is therefore a sexual process.

Ambivalence

Once the decision is made there are second thoughts. Even Susan, who wanted a baby so much, said "Are we sure we really want to do this? Oh, My God, we always thought about it, but this is a lot different" (S1). Christine talked about her fear. Is it the right decision? What about fatigue, the millions and millions of diapers, the losing of herself, the dependency, the vulnerability? What about her changing relationships? Will the baby be okay, be healthy? Work was manageable. How would she manage being a mother? In spite of these second thoughts, Christine said:

> I can't tell you how important it is for me to do this, in that I think it will make a difference in my life. You know there will be change and you can't anticipate making that change. It diverges the course of your life forever. Men never truly have to deal with that, ever. (C1)

Even for those women who are open to a child in their life, the actual move to becoming mother takes time, time that at once is both immediate and gradual. It is immediate in the sense of "no turning back," and gradual in that the decision is made again and again with each new change. Still, at times, one wonders if it could be a mistake. Am I really ready? Do I not have some doubts? Am I not somewhat afraid?

Of course, for others who have taken diagnostic tests (such as amniocentesis) to detect fetal abnormality, the decision becomes even more difficult. The woman may have already experienced movement, and heard the heart beat, and, now has to decide whether or not to accept this particular child in her life (Rapp, 1984). The contradiction that is seen in the use of diagnostic ultrasound in pregnancy, that is, making the baby more real holds the possibility of keeping the child at a distance in case there are problems (Hubbard, 1984, p. 334).

The opening to the possibility of being mother, the creation of space in one's life for a child, begins with the thoughtful decision but is experienced by the pregnancy itself and, even further as we shall discuss later, by the arrival of the child. The decision, including both thought and action, is the beginning of the change. With coming to the decision about children in their lives, women begin their transformation to mothers.

Chapter 5

WITH CHILD, BECOMING MOTHER:
THE TRANSFORMATIVE EXPERIENCE OF THE PRESENCE OF THE CHILD

The Meaning of Presence

Though women have chosen to conceive a child, they may not truly feel ready for the change that they expect is demanded of them. They say, like Brenda, "It's too soon," "I'm not ready." Or like Christine, "Will I be able to cope?" Or Jane, "I haven't done enough. I want to establish a career." This periodic (or maybe continuing) ambivalence and doubt is exemplified by Jane's statement, "I thought maybe I was a little too young to have kids" (J3). Jane is thirty-two. Yet, it is Jane who puts into words a recognition of her change through her own pregnancy. She said:

> Somewhere along the line the focus shifts. I can't pinpoint just when. I became less concerned about me and more concerned about the baby. The baby kicks and I can see the little appendages sticking out. That makes a difference. It is alive. It is real. I'm still apprehensive but not so ambivalent. (J2)

A woman does not make herself into mother—it happens through co-existence with the child. The presence of the child transforms the woman. Neumann eloquently speaks this truth:

> First, and foremost, the woman experiences her transformative character naturally and unreflectingly in pregnancy, in her relation to the growth of the child, and in childbearing. Here woman is the organ and instrument of the transformation of both her own structure and that of the child within her and outside her. Hence, for the woman the transformative character - even that of her own transformation—is from the beginning connected to the problem of the *thou* relationship .... Pregnancy is the second blood mystery .... The growth of the foetus already brings about a change of the woman's personality. (1955, p. 31)

The being "with" child is not the "with" that means "as a companion," or "next-to," or "in the charge of," etc. It could have those meanings, too, I suppose. Being "with child" is a primordial relationship, peculiar to women who carry within their own bodies the body of another. But it is not simply a biochemical mix. This relationship develops over time as the baby and the mother grow together.

Being with child is a comminglement, an entanglement, or an interlacing that goes beyond companionship. It is a mysterious union, unlike any other. Not only is the fetus bound to the woman through the nourishing pathways running through the umbilical cord but child and woman are truly one body. In spite of the separateness of their blood systems, the fetus cannot live without the oxygen and other nutrients which are provided through the remarkable capacities of the placenta. What affects the woman affects the child, and as the child grows so does the woman. They are one, an indissoluble whole, yet they are two. There is no closer union.

Thus, being *with child* moves a woman to motherhood in a unique, dramatic, and complex fashion. It is through her pregnant body that a woman comes to know herself as mother. It is through the woman that the child is created. There is no possibility for a woman to become a mother without a child, nor is it possible for a fetus to become a child without a woman. The presence of the child transforms a woman to mother. Through being "with" a woman a child is born. This does not mean a woman who adopts a child is not a mother. It is rather, that her experience of the child is different and therefore an adoptive woman's transformation to mother needs its own exploration and understanding.

The process in which men move to fatherhood, too, is different than women's move to motherhood. It can also be dramatic and powerful, but men who father will not experience the movement of the baby within. They do not feel the hiccups, the flips, the rolls, the startles of the developing child. They are not aware when the baby is still. It does not matter physically to the fetus how much their fathers drink (after conception). Men do not need to watch what they eat, nor do they experience enlarging and draining breasts. Nobody inquires about their weight, or wants to check their urine. They do not have to wear a different set of clothes for several months. They know too that they miss out in something that is distinctive to women. Bill, Anna's husband, said, "There is always going to be something dear and special about a mother and child relationship—such a close knit thing. It is just something I can't hope to penetrate. A father's love is just going to be different" (A1). This "close-knit" relationship, made possible by conception, is for most women a life-long reality precisely because of its intimate connection.

The Body "With Child"

Body as Vessel

"This *participation mystique* between mother and child is the original situation of container and contained" (Neumann, 1955, p. 29). The archetype of the feminine describes the female body as a "real vessel" which holds the containment as its elemental character (p. 44). Containment comes from Latin *tenēre* meaning "to hold together, to keep together, to maintain." It means to enclose. The female body encloses the developing child. Jane's ambivalence about her decision to have a child was gradually resolved through the child's actual presence, both in her body and in the actual care and nourishment of baby as a separate being. The body-as-vessel image need not be negative, such as, a woman as an empty-vessel, or a container for carrying the offspring of the man, but a positive image that shows woman as the essential participant in the growth and development of the child, and her own transformation.

> In the matriarchal world the woman as vessel is not made by man or out of man or used for his procreative purpose; rather the reverse is true: it is this vessel with its mysterious creative character that brings forth the male in itself and from out of itself. (Neumann, 1955, p. 62)

The fact that a woman is the essential participant in the creation of the child needs to be clearly remembered and acknowledged. This is crucial in all aspects of the childbirth dialogue—whether in discussion of birthing or in the present controversial issue of abortion.

Before conception there is no obvious space in a woman's body for the baby. The uterus is only inches big, and as a hollow, pear-shaped, muscular organ its ability to house an eight-pound baby is unfathomable. For the first three months, the baby's presence is not obvious to anyone, perhaps not even to the woman herself. She may know the child is there although it is difficult to actually imagine. She may start to feel different: heavy, tired, sometimes nauseated, with morning sickness, and her breasts may tingle and be tender. As the fetus settles and grows it pushes the uterus out into the larger abdominal cavity, it pushes the other organs aside. Within, and as part of the woman's body, the baby begins to show itself to the world. So it is both the expanding body of the woman and the developing fetus, together, that are creating the space for the baby. Jane remarked about her realization of pregnancy. Her period was a week overdue. She was having naps in the afternoon and her moods were very labile. She said, "I was not myself" (J1). Women wonder "just who they are." This is what Young (1984) calls a split subjectivity or a de-centered body subjectivity of "myself in the mode of not being myself" (p. 48). The inner movements belonging to another, "another that is nevertheless my body." The normal bodily boundaries shift—one wonders where one's body begins and ends—the body's integrity is put into jeopardy. Brenda expresses surprise as she attempts to wear her winter coat from last year. In her mind's eye she holds the image of her pre-pregnant body, so that the way her clothes fit remind her that she is changing, remind her that she carries another being within. As Katherine finds it hard to move through a narrow space, she attempts to pull in her stomach—which, of course, no longer solves the problem. Or when looking in the mirror, Jane exclaimed, "Holy Smokes! Where does all that skin come from" (J2)! She is surprised at how she has grown. When the baby moves the woman is reminded of her change, and when people respond to the baby first (glance first at her abdomen then her face) she may wonder "Who am I?" Or as Christine said, "Am I not a woman anymore" (C1)? Or Brenda, when treated "like I am going to break" said, "Leave me alone. I'm only pregnant, not a baby" (B1)!

Young (1984) calls this pregnant consciousness a double intentionality. There is a split between the tasks at hand. The one task is to have a baby, and the other, the awareness of the woman's own daily tasks and projects. "To be sure," Young said, "even in pregnancy there are times when I am so absorbed in my activity that I do not feel myself as body, but when I move or feel the look of another I am likely to be recalled to the thickness of my body" (p. 51). When women hear the heart beat, when the baby moves, or when the baby is seen through ultrasound examination the true intention is evident (that is, to have a baby). Yet this intentionality, this felt presence of the baby, sometimes breaks down and a woman may think, "Maybe I am just fat?" Susan wanted to be sure that others knew she was pregnant, "I kept saying to Paul, 'Do you think they can tell I'm pregnant?'" (S1). Anna, although she knew she was pregnant through her own calculations, by her slight morning sickness, through the doctor' examination, through the positive pregnancy test, begins to doubt. She said:

> Intellectually I *knew* but when I felt a kick that was pretty exciting. And then at 20 weeks I heard the heart beat. The midwife acknowledged, "Yes, it is really there," which answered

> my question exactly. That was really an important day for me. (A1)

So Anna knew again of her pregnancy and the purpose of her changed body. A woman's knowledge of pregnancy and her transformation to mother is a process—a process that deepens her understanding of what she already knows (Polanyi, 1969)—becoming what one already is.

Young points out that women's experience of their bodies in pregnancy is different than when one's body breaks down in illness and fatigue. As women we can "become aware of ourselves as body and take an interest in its sensations and limitations for their own sake experiencing them as a fullness rather than a lack" (1984, p. 50-51). Thus, the pregnant woman has the unique experience of being aware of her body as being *with* child while accomplishing her tasks. "You just think twice about what you do," said Brenda(B1), "Before I would climb up all the boxes and pull down a 45 pound box from the cooler. Now I think, 'Am I going to fall when I climb up there? Am I going to lose my balance? Will I get dizzy?'"

But this experience of accepting one's enlarged body, or of "thinking twice," may not necessarily be an easy one. It was not until Brenda's eighth month, in talking about her changing body, that she was able to say:

> Maybe I am getting used to my body. Now it doesn't seem so bad. When the baby moves you can see the ripple across your stomach. It seems like he or she is going to leave. That is why you are so big. It is not like you are just fat anymore. There is someone there. (B2)

Before that it was hard for her to accept "even if you understand it is a baby growing inside you—there are deposits of fat and stuff. It disgusts me—so far it is hard and firm but you know it will be jelly later on" (A1). The child's presence, through its movement, its reality of a separate person, allows Brenda to accept her own body, her body *with child* as her own. Others, also, experience their growing body as ugly. In a society that celebrates slimness it is not hard to understand the difficulty women have with accepting their growing bodies, especially when they have not yet truly experienced the presence of the child. But for Anna, Christine, and Katherine, it was easy. They enjoyed watching their tummies grow—feeling the hard roundness, appreciating their enlarged breasts. They enjoyed the presence of the child but they still wanted to look good, that is, not "frumpy"—nor did they want to hide their pregnancies. The body as vessel, for containment and nourishment of an other, transforms woman to mother.

Maternity Clothes

How does a woman clothe this transformed body? The move into maternity clothes is a public acknowledgement of the presence of the child. Before this outward affirmation friends and acquaintances may wonder and speculate about the likelihood of pregnancy. Clothes tell the story. Especially in present society where women change to specific maternity clothes which tend to have a characteristic appearance. Katherine, Susan, and Anna talked about their efforts to find clothes that express their own individuality, and their own approach to accommodating their growing bodies. They said, for example:

> Clothes have a tendency to deny the whole state of pregnancy because they have ruffles, and bows, and lace and everything else at the neck—to detract from your tummy. It seems they try to make me look like a virgin again. (A2)

> Just bags. I'm not trying to hide my pregnancy but the clothes are just huge with puffed sleeves, and heavy-duty gather—which is baby-fying. I don't want to look like that, or to feel like that. (K1)

Like Katherine, some of the other women were glad that they could sew so that they could wear the clothes that they felt comfortable and that made them feel good about their growing bodies. Nor did they want to wear clothes that would reduce them to the childlike image that could even contain the suggestion of virginity. According to Brownmiller (1984), clothes make a statement. Clothes never shut up. They gabble on endlessly, making their intentional and unintentional points" (p. 81). How does the "statement" made by a woman's clothes affect her transformation to mother?

Chicago (1985) said, "Maternity clothes are obscene. They neuter the form and reality of the pregnant women by using inappropriate materials—little flowers, chintz, small plaids and checks—nothing to bring attention to the miracle and power of birth" (p. 123). Anna's husband suggested that the ruffles, bows, and lace were used to help the pregnant woman feel more feminine, or, as Anna said earlier—trying to detract from the tummy (the growing child). Has femininity really been reduced to the "cutsie," the sweet, represented by the puffed sleeves that Anna, Katherine, and Susan did not want to exemplify? It is small wonder that women sometimes feel dependent on "experts" to guide their actions in pregnancy and in birth when they are encouraged in a "kind of infantilization" (Seiden, 1978, p. 92) to which some maternity clothes contribute.

How much more in keeping with the power and miracle of the growing pregnant body is the fantasy of Chesler (1979) who wanted to wear a "hundred-breasted, thousand-jewelled garment of sapphire, a great coat of many colors. . . . Large, exotic clothes to loudly and gorgeously proclaim the miracle of her child's passage into being (1979, p. 33). Of course, Chesler acknowledged that such clothes cannot be found nor would there be any place to wear them—but her fantasy suggests the desire of women to express their own strength and the excitement and wonder at this time of intense and radical change that comes with the child's obvious presence.

Clothes that speak of the strength of femaleness, of femininity, and of the power to become a mother, support a woman's change in a powerful way. In a "society [that] often devalues and trivializes women, regards women as weak and dainty, the pregnant women can gain a certain sense of self-respect" (Young, 1984, p. 52). Clothes that express a woman's own personality, neither denying her pregnancy nor her sexuality, would help her to celebrate the wonderment of her bodily presence of the child, and assist her in the move to becoming a mother.

The Child's Presence in Relationship

Toward the end of pregnancy women are tired of the big clothes and long to "get back into their jeans." There is a point when the presence of the child becomes a burden. Anna said, "I think I've come to the point where I'm sick of being this huge. I don't get much sleep. I go to the bathroom every two hours. You've got your right side and your left side, can't sleep on your back. But I'm sure it is nature's way of getting me ready" (A3). It almost feels that a woman no longer owns her body. The baby takes over and the woman merely goes along "unneeded by Nature's work" (Chesler, 1979, p. 65). The difficult period of final waiting begins—the waiting for the actual child. The relationship with the baby starts in pregnancy. "The baby's movements within my body remind me to keep in touch," said Christine (C2). Jane, who thought that it may be easier to carry the baby inside rather than outside, begins to feel ready for the child "when I feel the active contractions my focus begins to shift to the thought of the actual child" (J2).

Touching

The women spoke of their relationship with the baby they carried—talking to it (him or her), touching, feeling the movement, noting the movement, sensing the rhythm. It was an intimate relationship that no one else shared. Christine said:

> Part of my relationship with the baby inside was the patting of myself, feeling him kick, responding to this kicking, and touching my abdomen. I felt really good about the shape, the hardness, and the roundness—loved rubbing cream on. It felt so good. (C4)

Other people too, sometimes want to feel the baby by touching the woman's tummy. At first the woman may feel confused, "What are you touching me for? How can I tell them I don't like it?" When the "toucher" was a male superior at work and when there wasn't much yet to show, Anna said, "I was not sure how to act" (A1). For Brenda it was, "they want to feel the baby kicking which really embarrasses me. Like it is too personal" (B1). Of course, if it is someone close to you, "It is terrific," said Anna. "My mother is coming for a visit and says that she wants to come to feel my tummy" (A1). Katherine statement shows the paradox of this experience, "I don't think they were patting my stomach even though it was my stomach they were patting" (K1). The body being touched is one's own, yet it is the baby that is being touched.

Touching of a woman's body, as baby, again shows the remarkable and unique experience of pregnancy—being another while being oneself. As the baby grows bigger there is less confusion. It is more obvious to the woman herself, and the person who reaches toward the woman/child, just who is being touched. Towards the end of pregnancy it may be that one loves to have people touch one's baby who now is obviously present. Bill, Anna's husband, talked about the attraction of the pregnant woman's tummy, "I can understand it, because it is almost irresistible. To feel her tummy is just great. I feel my sister's tummy too and it feels different. I can understand why men do it. It draws me to it—it is a fascination" (A1). There is something about the roundness of the pregnant tummy that invites touching. Is it like the soft smoothness of the baby's cheek or the intrigue of the lover's face? The desire to touch the woman's tummy to feel its firmness, roundness, and the movement of the baby is perhaps the acknowledgement of the mysterious presence of the baby within the woman. "The inside maybe is the baby but the outside is me," said Susan (S3).

Sexual Touching

Although the women did not readily speak about their experience of sex during pregnancy, Christine described the changed relationship with her husband. "It is still good," she said. When she asked him if it was different for him, he admitted that it was, "I just feel different about what the vagina is for and what the breasts are for" (C1). It makes one understand that women's bodies are made to accommodate a child and the child's presence makes that obvious. A pregnant woman's body has a different kind of richness, perhaps "awe-inspiring," which according to Barber & Skaggs (1975) is a "primitive signal perhaps reaching back to the beginnings of human life." Bill said of Anna, "I thought she was radiant before, you know (honestly), but since she has become pregnant I can't take my eyes off her. There is a radiance about her that I'm fascinated by" (A1). This fascination may be an acknowledgement of something holy—a reverence for life. It may also be a confusion about the whole sexual nature of the childbirth.

> Before you were pregnant nobody talked about sex or anything like that. But once you are pregnant the taboos all go away, everyone knows you've done it so it must be legitimate to talk about it. It is really weird. (J1)

> All of a sudden they found that you're pregnant, and my goodness, you can't hear this joke. All of sudden you've regained your chastity and you're Miss Innocence - Maybe they think the baby can hear. (S3)

Is this confusion an expression of the separation of sexuality and pregnancy? Niles Newton, psychologist, and early (in the 1950s) supporter of breast feeding, notes that in the female reproductive triad of coitus, birth, and lactation, there is a tendency in our society to place special emphasis on the first ... and ignore the sexual aspects of the latter two" (Seiden, 1979, p. 91). In the "awe" of the woman with child, there is a danger of ignoring or down-playing the sexual nature of this experience for women. In a society that sometimes discourages female sexuality, as well as assertiveness and aggressiveness, one is not sure how to act in the presence of the pregnant woman.

Vulnerability

"There are these guys in the office, very old-fashioned, who when I come into the office—it is like, 'You'd better sit down,' sort of like I am crippled or something" (C1). At first it seems strange but as the pregnancy progresses women experience a changed sense of themselves and their need for others. They begin to feel vulnerable and more willing to accept the attentive support that was offered them through much of their pregnancy. Christine said:

> I have felt more dependent than I have ever felt in my life. I feel physically vulnerable, that is, if I am with a bunch of people in a crowd, I could easily be thrown off balance. Through the winter, especially, when I am driving the car, I don't want these crazy drivers coming near me. It is just that there is a baby here! Just lately, in the last three weeks, I feel careful about what I lift and haul and carry. Before it would be hard for me to let someone else do it. I mean, I am very strong and feel very strong and very capable and "I can do this!" (C2)

A woman may experience others as considerate and protective: colleagues who leave a parking space next to the door, fellow workers who lift heavy boxes, racket ball partners who no longer want to play, or a father who think his daughter is working too hard. Since she feels more vulnerable she is therefore more accepting of offers of assistance. Earlier in pregnancy the woman may often have resisted or even resented offers of help, late in pregnancy she tends to be appreciative. It is not just the fact of the large and at this time awkward body, there is an attitude change that has to do with the relationship of mother and child. "I'm careful when I cross the road now—before I just charged across. I've changed and Nathan has responded to the change. He is protective of me because of the presence of the baby" (C1). To protect the relationship with her child, the woman accepts her vulnerability and need for others. "I think it is kind of preparing me for the fact that when the baby comes I am not going to raise it by myself. I am going to need help," said Anna (A2).

But again, as with all human experience, the sense of vulnerability and the need for protectiveness is more complicated. There is a protectiveness that men feel toward women—both Anna's and Brenda's husbands expressed a desire to lessen the anguish (A1, B2). But Anna felt it has gone too far:

> You see, I don't think that protectiveness is necessarily a valid feeling ... because women are built for this situation. The body takes care. The body does it all. We don't need episiotomies, we don't need enemas, we don't need to be shaved. Our body takes care of it. (A1)

Brenda reacts when Tom makes decisions for her such as ordering milk instead of coffee at lunch, and when he wants her to have a Cesarean birth because he sees it as more humane. Women are beginning to identify, for themselves, the ways in which protectiveness is appropriate or not. To be supportive of the vulnerability that occurs with the presence of child, while fostering the woman's own sense of self as a capable and responsible woman, can support rather than hinder a woman's transformation to mother. Anna and Christine, both very independent women, spoke at some length about their need for a sharing relationship in the project of parenting. They felt the experience of carrying and giving birth had helped them to realize and accept their need for others.

Temporality of the Child's Presence

The Due Date

"What is your due date?" "When are you expecting?" are questions repeatedly asked of a pregnant woman. Such questions are based on the sense that the childbirth process ends with the birth of the child, and nothing is to be done but wait and watch. And, of course, this is true. That is, pregnancy ends. The child is born.

> I was still waiting at the end of my tether—because it really felt like a long time, and because you are so awkward at that point too. I was anyway. The midwives weren't concerned and neither was Mike. He said, "Come on, why do you expect the baby to arrive on the day that somebody sets because of some formula." And I know that is true, but I kind of hoped she would arrive on time. (K3)

In terms of a woman's transformation to mother, the "due" date is just one moment in a larger endeavour. The temporality of the move to motherhood cannot be limited to such a linear time frame as "waiting" during pregnancy. The presence of the child is experienced by a woman as a time of movement, growth, and change (Young, 1984, p. 54). Throughout pregnancy she experiences herself as source and participant in a creative process. "Though she does not plan or direct it, neither does she let it merely wash over her; rather, she *is* the process, this change" (Young, 1984, p. 54). So not only does time stretch out toward a "due" date but the moments and days take on a depth that reaches into her very self, her body—and transforms her. Anna put it this way:

> The birth itself is one event on a continuum, not an end in itself. I think it has to be that way. The gestation period is nine months, and I think that with every month and every week you are able to go further and further beyond the birth. I mean you are focussing on the birth date—the birthday—but for me the further along that I am pregnant, the more I am able to see beyond that. (A2)

Could it be that the pervasive search for the due date disregards the transformative process that a woman experiences? Does the focus of the due date disregard the day-to-day growth and development of the mother herself?

The pregnant woman is called expectant. She prepares herself for the birth—she prepares herself to be mother. As she focusses on "zero day," as Anna said, she also waits for herself to become a mother. Katherine (K2), eight months pregnant, said she did not feel like a mother, "Maybe it happens when you have a child, and have worked out things with your child." Yet, in the next breath she described a change that she notices in herself, "The other day at the doctor's office, when I held a little (two weeks old) sleeping baby on my chest, I felt kind of choked up, a little bit, kind of teary with a baby that small." She was being opened to the possibility of herself as mother by the actual life she carried below her heart.

The focus of attention on the "due day," or the Expected Date of Confinement, may be a form of waiting that is found in the world of instrument-machinery (Fujita, 1985). Such an instrumental, means-ends, type of waiting can be contrasted with waiting "in the natural world," or waiting "in the world of becoming." Waiting in the natural world involves trust in the power and process of nature which are independent of human operations and attitudes. Waiting in the world of becoming, which is "becoming ourselves, becoming more human," or maybe, "becoming a mother," involves a dialectic between "how we wait" and "what is waited for." "In the world of becoming, we can even say that the very ways of 'how we wait' enables us to be aware of what has been out of our reach and, thus, enriches, and transforms the initial 'what we waited for'"(Fujita, 1985, p. 113). Attention to the experience of the woman herself during pregnancy attunes one to the very real growth and change that occur for women during their experience of bearing a child.

The Presence of the Child Transforms Space

> Maybe I can talk about how I feel about the world. I'm more introspective—catch myself daydreaming at work, and just thinking about the miracle of creating a life ... what is going on inside is wonderful—I have more concern about mankind and justice. (A1)

The pregnant woman notices that the world is full of pregnant women, mothers, and babies. When I said to Katherine that I had not noticed many pregnant women she did not believe me. "Oh, come on!" she said, "There is a baby boom. It is incredible" (K1). Others, like Jane, said they watched the interaction between mothers and babies. They noticed what they eat and drink, whether the mothers smoke, what they do, and what they say to their children. They want to know how one lives, as mother, in the world.

And the "world" noticed them too.

> If you go into a crowded place, a lot of people stop and look at you and smile at you. Whereas before you would just walk in ... We went into the lounge for a drink, and I find that people really make you feel uneasy, like you are doing something terrible, and you are only drinking orange juice. Like "come on!" (B1)

> Saturday night was our Christmas party. I was drinking orange juice, good healthy stuff ... When I get up to dance everybody around you, "Careful, Mom!, Should you be dancing, Mom?" It is just, "Oh, I'm pregnant, I should sit in my corner." (B2)

> It feels a little odd to be pregnant and sitting in a bar. It really does. (K1)

It is confusing. With the presence of the child in her body, a woman sees the world as changed and experiences that changed world in various ways. Brenda, as we heard, did not want be seen differently—she wanted to be just herself. Katherine, on the other hand, saw herself as changed, and began to question her actions. Both begin to question what is appropriate behaviour for a woman with child? Maybe pregnancy is a time when women are "exercised" into motherhood as suggested by van Manen (1986). Women begin to see how to act in the world as mothers.

Chapter 6

THE DIALECTIC OF SEPARATION AND WHOLENESS: THE TRANSFORMATIVE EXPERIENCE OF BIRTHING PAIN

Can Birthing Pain Have Meaning?

> Out of this woman is borne the universe; on her belly is a primordial scene, rich with soft rolling hills and a river teeming with life. . . . This piece is a celebration of women's power. (Chicago, 1985, p. 22)[1]

Many women seem to want to prepare for the actual birth experience. They do so by attending childbirth classes, by reading the ever-growing supply of childbirth books (many of which are now written by women who have been through the childbirth experience themselves), and by talking to friends and colleagues, doctors and nurses, and others. In the preparation and anticipation of birth, women are surrounded by thoughts of the pain that they will experience. I recall after teaching childbirth classes for a number of years I was asked by a woman from one of these classes, who had had a long and difficult labour, "Why didn't you tell me about the pain?" I was taken aback because I thought I had. But how does one talk about the pain of childbirth? It is usually the aspect of pain that surfaces in the horror stories. It is the pain that one is said to forget over time. With labour inevitably comes pain for most women, and it is the pain that is thought about during pregnancy:

> Now I'm starting to question and wonder about my ability to handle the birth-thing—that whole process without drugs—and though I'm committed to that whole idea, will I be able to handle it? (A2)
>
> I figure it is going to hurt so why worry. It is going to happen. It is not going to hurt for 15 years, just a day or so—not like an illness. (B1)
>
> I'm not worried about the labour and delivery really. If for no other reason than that thousands of women do it—and it is for a short time. (J2)
>
> I'm waiting to compare labour pain to a headache. I have headaches that last for a day and a half, maybe two days—and I can stand that. (S3)

The pain comes from the experience of separation of mother and child—physically generated by the tumultuous rhythm of the contractions which open the cervix to allow the passage of the baby down the birth canal and thrust the baby into life as a separate being. The pain is also the splitting of the unique and particular unity of the mother and child exemplified by "the presence of the child" (Chapter 5). According to Rich (1976), "the pains of labour have a peculiar centrality for women, and women's relationship—both as mothers and simply as female beings—to other kinds of painful experience" (p. 15).

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[1] From a description of the embroidered image of *Creation of the World* by one of the women who worked on the piece.

Throughout pregnancy Susan talked of not trusting her body, about her eating habits, her clothes, her aches and pains, and her vulnerability. It seems that her body was experienced as separate, as disembodied from her being. Even her baby was not a part of her. "It's sort of somebody down there, but not an extension of myself" (S3). Yet after the birth Susan talked about how the labour, and the pain, had brought her and her husband closer together, and how she, too, seemed to become more integrated and whole. She related the painfulness of this experience to other painful experiences in her life, her mother's illness, and the breakup of her first marriage. It seems that the pain may be one experience that contributes to a woman's transformation such that Susan could say, "I look back and can't believe how I used to be. I can't recognize who I was" (B3).

One has to wonder if there is something important in the pangs of childbirth that is true for all women, those who pleasure in its labour, those who endure, and those who suffer. Some births are short and intense, some long and exhausting, and some need medical intervention and treatment with forceps, medication, and Cesarean delivery. Christine experienced intense, excruciating pain (partly due to the use of forceps) and yet two months later said, "I'm glad I didn't miss it and I would wish other women could experience it." Then she paused and wondered, "Why did I say that?," and goes on:

> I don't think one should focus on the pain, that women should have to experience pain. But in the pain there is an experience of being inward and involved in feeling the pain—not enjoying it but taking hold, enduring, or whatever you do to handle it—and knowing that it is going to produce a child. That is what it is, not to focus on the pain, but to see what the pain does to you, how it changes you. (C4)

Is it possible that the separation, and its accompanying pain, is a penetrating aspect of a woman's transformation? What can birthing pain show us about a woman's transformation to mother?

Letting Go Assumptions

In order to explore the nature of birthing pain, it is important to let go, for a moment at least, of some of our current assumptions and beliefs. These may include ideas that:

Pain should be denied. Some childbirth educators have thought that by removing the word "pain" from the language of birthing, they will prepare women to take a more positive posture and to accept more readily the challenge and joy of the birth. Some talk of "contractions," others refer to "rushes," or "discomfort" to mean the experienced pain. Anna said:

> Early in pregnancy I had felt that I am not going to see this as a painful experience, I'm going to relax, and go with the flow, but after having listened to a tape of a woman in labour, and hearing about transition, and how disorientated you become—a very tough time—really dispelled any notions that there would be no pain . . . Pain really does exist. (A2)

While a woman's positive attitude is important, denial of pain may create expectations not borne out in reality. What is being denied in the denial of birthing pain?

Pain must be relieved. The belief that pain must be relieved pervades our society, from the advertisement of over-the-counter drugs to the medical need to "give something for the pain." Although human suffering must be prevented or reduced, let us stand back from the expectation that relief or removal of the pain of childbirth is a primary and necessary goal. Rich (1976, p. 152) suggested that this notion "is a dangerous mechanism, which can cause us to lose touch not just with our painful sensations but with ourselves." Could it be that the fear and anxiety of this truly female experience stand in the way of drawing on the fundamental source of life and spirit women have? Fear of the pain may be a result of tales, anecdotes, literature, and medical approaches to childbirth. Until recently, the written texts about birth came from the hands and minds of men who had observed and described but had not experienced. The knowledge and the support that was originally available to women, from mother to daughter, from midwife to labouring woman, from older to younger, is once more becoming available. The reclaiming of the childbirth experience by women has done much to dispel untruths and has reaffirmed women at the center of birthing practices. Birthing is their experience. As women accept their bodies, their bigness, their appetites, and their feelings as well as their intellect, they will regain their sense of power. Rich (1976, p. 292) said, "we need to imagine a world in which every woman is the presiding genius of her own body. . . . Then women will truly create new life." What is taken away in trying to relieve women from the pain of giving birth?

Pain is only negative. Childbirth pain is a normal accompaniment of birthing and may arise from dilation of the cervix, the contraction and distension of the uterus, distension of the outlet, vulva, and perineum, and from factors such as pressure on the bladder, rectum and other pain sensitive structures in the pelvis (Bonica, 1975; 1984). Birthing pain brings life. The fact that childbirth is now primarily a medical event, occurring in an atmosphere associated with sickness and death, supports the underlying notion that the pregnancy-birth event is a disease condition. In a nursing text on pain (Meinhardt & McCaffery, 1983), labour pain is included in the chapter on pain syndromes along with phantom limb pain, trigeminal neuralgia, arthritis, headache, and pain syndromes associated with cancer. In fact, the term "syndrome" is defined as a "a group of signs and symptoms that collectively indicate or characterize disease, psychological disorder, or other abnormal conditions" (Morris, 1978, p. 1305).

Of course, there is a danger in romanticizing pain. We know childbirth and its pain has taken its toll, with death and horror so vividly described in medical case histories as well as biographies and novels. It is small wonder that women have welcomed prescribed anesthesia, believing it would mean less pain and danger at birth (Hubbard, 1984, p. 338). At one level pain is a sign of distress and possible danger but birthing pain can be normal and brings life. Can birthing pain be shown to be a positive normal experience?

Pain is punishment. The word pain derives from the Greek *poinē* meaning penalty. This origin is suggestive of the notion that women are being punished for the "crime" of pregnancy, or symbolically, for tasting of the tree of knowledge, that is, "knowing too much" (Seiden, 1978, p. 95). Is it possible that non-acceptance of the pain, or the fear of pain, comes from women's non-acceptance of or alienation from their bodies, leading to fear of helplessness, fear of dependence, and fear of behaviour? Rather than accepting the notion that childbirth pain is a punishment to be mutely accepted, one wonders if women could be seen to acknowledge their physical-ness, their passion, their sexuality, their whole female existence, childbirth pain may be approached as a challenge and opportunity. Yet even here there are limits between ennobling pain and self-destructive hurtful pain. But can giving birth be an event of proud endurance of pain in the service of a desired goal, not unlike contact and endurance sports (Seiden, 1978, p. 101)? Can birthing pain be seen as an opportunity and a challenge?

Pain can be explained. There are theories that explain childbirth pain physically, psychologically, sociologically, and culturally. These theories and explanations contribute to our understanding of pain, but they also fragment the sense of wholeness of the pain experience. When we explain, we stand apart from the phenomenon and observe, trying to fit everything into systematic order thus belying the mystery (Olson, 1986) and women's participation in that mystery. Exploring the phenomenon of birthing pain is an attempt to grasp that primordial wholeness of the experienced pain—the participation of women in their pain. What is the nature of the experiential wholeness of birthing pain?

Can Birthing Pain be Described?

Birthing pain, like other pain, is difficult to describe. "Its resistance to language is not simply one of its incidental or accidental attributes but is essential to what it is," said Scarry (1985). "This resistance to language is because physical pain, unlike any other state of consciousness—has no referential content. It not *of* or *for* anything" (p. 5). But here we need to look again. The pain of childbirth *is* different than the enveloping effects of other pain: "these pains one could follow with one's mind" (Margaret Mead, in Sorel, 1984, p. 339). And birthing pain produces a child. However violent and terrible the pains are, this connection needs to be remembered: "I reached down and took him out . . . put him on my belly . . . I couldn't take my eyes off him" (V). Or as Susan said, "You get a prize in the end. You've accomplished something that you can look back and say, 'Gee, I did that'" (S3). Thus, what is at stake is the meaning of the childbirth pain so more than just the physical sensations of the pain need to be taken into consideration. If birthing pain was likened to the pain of mountain climbing, the pain of running the last few yards of an Olympic race, the pain of the downhill skier in search of the gold medal, rather than the pain of arthritis, cancer or other illness (Melzack, Taener, Feldman, & Kinch, 1980), would that change women's preparation for and attitude about the pain?

> I use the analogy all the time—bicycling. We just telephoned a friend this morning who was on our cycling trip with us and I said, "Dave, you know, when I'm in labour and doing all that hard work, I'm going to be thinking about going over that mountain . . . I was reduced to tears [on that trip] because of my frustration, and because I couldn't breathe . . . but I mean, I did it . . . I made it on my own power. (A2)

If childbirth pain was embraced as part of the mastery of worthwhile activity, it may not be thought of as hardship (Kittay, 1983, p. 124). Childbirth pain is *of* and *for* the child, and in this fact is contained the possibility of personal good, "I did that," or as Paula said, "I can do anything now" (P1).

Women described the pain as powerful, intense, overwhelming, cramp-like, stretching, burning, pressuring, tiring, and exhausting. They said:

> I withdrew into myself, had few thoughts. (H)
>
> I was immersed in a physical sensation, lost awareness of time and what was going on around me. (V)
>
> I feared that I wouldn't be able to stand the pain—would lose control of myself—maybe even die. (P)
>
> I was brought to the core of myself. I was pitted against myself. (H)
>
> It was definitely, definitely painful. When she crowned it hurt a lot. I can't deny that. But as each hour passes the memory gets less pronounced. And look what I have to show for it. . . . [seven months later] I've almost forgotten—am surprised how easy it was. (A4, A6)
>
> I have a picture in my mind's eye of being in pain, but I can't remember the pain. (J3)
>
> After the birth I almost had a feeling that perhaps I imagined the pain. Was it really as hard as I thought it was? (P2).

"Who can remember pain once it is over?" wrote Atwood (1985), "All that remains of it is a shadow, not in the mind even, in the flesh. Pain marks you, but too deep to see" (p. 135). It is a bodily pain: "I am my painful body."

I Am My Painful Body

> I had my first contraction in the bathroom. It came from nowhere—an internal tornado picked up and hurled every organ toward my skin but nothing showed outwardly; the force was wholly absorbed. I couldn't recognize my own body in pain. I endured two before the words came to me: I am in labour. (Israeloff, 1982, pp. 86,87)

Childbirth pain is something deep and powerful: "It is different than [other pain] I've ever experienced—low back pain—deep pubic pain" (V). True, there is the localized, more surface pain, such as the burning and stinging as the tissue stretches to release the baby's head, but at the same time, there is that deep inner pain which expresses itself as "being in pain."

Being in Pain

The inwardness of childbirth pain is experienced by the feeling of unreality. Of being in a fog. Or a sense that time has stopped, is going on forever, is irrelevant. There is little awareness of the people around. "I don't remember what was talked about. I was totally inward" (1). The origin of the word "birth," from the Old Norse *burdhr* or *bher*, means to carry, to bear children. The carrying, the holding of the child, the woman-body-vessel (Neumann, 1955) is the nature of life. As a woman, I *am* this body, I *am* this pain. Birth, *bher*, also refers to bearing as an enduring. To bear, to carry on, to endure the pain is a part of the birth experience.

Pain is experienced by one's stance in relation to it—as a woman of autonomy and personal power or as a woman at the mercy of the environment or the doctor, alienated from her body and subject to fearful thoughts and imaginings. As women accept and take hold of their power, to figuratively and literally "stand up" and actively birth their own children rather than be delivered, as in the vulnerable "lying on one's back" position, they do not deny the pain but carry it. The pain-as-experienced is empowered by their way of standing in relationship to it: their riding with it and enduring it, or their being overwhelmed by it. Both enduring and suffering are experienced by women.

> Something was amiss, the next contraction on its way. Assuming that I was in the first stage of labour, I began the appropriate breathing technique—carefully paced inhalations followed by gently blown exhalations. It worked in the sense that without it I'd have been swallowed by the pain and with it I could contend. But I had never been less distracted in my life. Nothing else was in my universe but the pain. (Israeloff, 1982, p. 86)

In the attention to the pain there is a realization that the pain is not static and unchanging but something dynamic and moving, and the power of attention can become a key factor in working with the pain and lessening the pain. By focusing attention inward, we can gain a better understanding of the numerous signals our bodies transmit regarding what to do to help ourselves through the pain (Heckler, 1984, p. 61). The body has wisdom of its own which does not lie (Woodman, 1985) but perhaps needs time to find its own rhythm. The universal acceptance of

Cartesian philosophy, which separates mind and locates self-hood with the "thinking thing," *res cogitans*, has invaded our thought to such an extent that there is danger that we have lost touch with that body wisdom, the "material being," *res extensa*. In childbirth pain embodiment—understood in the notion "I am my body"—becomes a concrete reality not to be ignored. Merleau-Ponty reminds us that it is our bodily presence in the world that makes knowing possible: through our body we speak to the world—because the world in turn speaks to us through our body (Martel & Peterat, 1985).

Yet the regular, intense, continuous contractions take their toll of energy and resources. Exhausted with the pain of fatigue, the feeling is one of "I just cannot go on." "Too tired to say anything, I push with all my might. I'm the Lilliputian. I may not be able to do it. It's beyond me to give birth to you" (Chesler, 1979, p. 115). The work, exertion, effort, is not just the physical power of the uterus, nor is it just the intellectual power of the mind, but the unity of self which calls women to use all our resources. Women carry on, especially if aware that the baby is soon to be born. Of course, there is no other option. "There is no turning back, you are in it. The only choice is your attitude about it. With a good attitude it is so much better" (A4). [2]

The pain of labour demands action. Grunting, screaming, walking, finding a comfortable position, active relaxation, breathing patterns, focussing attention, or having a bath. Any of these may free women from the state of passively suffering. Women have said things like: "I didn't know what to do and needed someone to help me" (X); "I tried to find a comfortable position, was impatient, angry, and shaking" (F); or "I screamed, or wanted to scream, to bite on something. I cried because it hurt so much" (E). We need to ask, "what can be done?"

The Cry of Pain

"I will cry out like a woman in travail. I will gasp and pant" (Isaiah 42:14). The Australian myth of Eingana (The Great Earth Mother, fertility herself, the source of all life, all forms of being) gives a clue to this cry:

> Eingana's travail to give birth is also the explanation of the sound made by the "bull-roarer" in the Kunapappi ritual . . . . Eingana was rolling about, every way, on the ground.

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[2] Carol, Anna's sister, after a thirty-six hour labour (A4).

> She was groaning and calling out . . . making a big noise. (Meltzer, 1981, p. 11)

A big noise! "The noise came from where? My depths for sure. It amazed me. The bull's roar—a perfect description for what it felt like and sounded to me" (P2). Anna, too, talked about the "primal, guttural kind of noise that came when pushing, and the whinnying noise while crowning. Making the noise helped the effort it seemed" (A4).

> These cries amazed me. With my first child, I hadn't felt any desire to scream or cry. Now I had the impression that I was rousing the entire hospital. Never in my life had I wailed like that before. It was as if the cries didn't belong to me. . . . At one point I heard myself crying out in a different way: long, trembling howls, like the cries of a baby. I realize now that these cries protected me, not from the pain, but from a traumatic inscription of this pain on my psyche. It was a kind of catharsis; by screaming, I let the pain leave my body. (quoted in Odent, 1984, p.55) .

Earlier in labour there may be moments of laughing. I recall Paula. There were times during the long day of labour when the house rang with her boisterous laughter. Perhaps it was as we manipulated her labouring body through the awkward space to have her sink into a tub of warm, soothing water, or maybe it was when some funny incident triggered a hooting guffaw. "Laughing felt good," she said later. Jane, too, was surprised at the fun her sister-in-law had in early labour:

> They were giggling and laughing, counting contractions and having a great time. Finally they left for the hospital at 1:30 a.m. Melissa was having some discomfort, but not obvious pain. She was able to joke through it. (J2)

Crying, laughing, the bull's roar, the screams, the whinnying, all express the woman's experience of the pain and the intensity of labour. She may not even be entirely conscious that the sound is coming from herself (Barber & Skaggs, 1975, p. 39).

Giving voice to women's pain, the pain of childbirth, assists women's use of the pain experience to express themselves and the reality of their world. It transforms women's experience of pain to something useful to them.

> Near the end of my labour, I began to curse. I can't remember what I said: I had lost control of my senses. That experience has outlived the actual moment of birth. To think that I could act like this in front of other people! Yet it was as if, after losing my own voice for so many years, I had finally found it again. (quoted in Odent, 1984, p.55)

Nonetheless, pain should not be stoically endured by women for some psychological or physiological value (Meinhardt & McCaffery, 1983, p. 237). By giving voice to pain women may help themselves through it. Women can use the pain to express themselves rather than let the pain defeat or belittle them.

Finding a position

In 1884, the doctor Engelmann, in an ethnographic account of labouring women from various cultures wrote, "the parturient must be guided by her own actions, and in a position assumed by her own comfort and by the dictates of her instinct . . . . The recumbent position retards labour and is inimical to easy, safe, and rapid delivery" (p. 149). Odent, another doctor, nearly a hundred years later (1981), after the recumbent position had been used almost routinely by obstetricians, hearkens back to the instinctual knowledge of the body.

> These last years, we understand better and better what to do to help the mother become more instinctive, to forget what is cultural, to reduce the control of the neocortex, to change her level of consciousness so that the labour seems to be easier. (Odent, 1981, p. 9)

If women obey their own impulses and become more instinctual, they may assume a squatting, kneeling, or sitting posture. According to Engelmann (1884), "this would . . . often do away with the necessity of resorting to the forceps, which, though a great blessing, too often become the reverse in the hands of eager obstetricians, who are inclined to use them on the least occasion, or without any real occasion at all" (p. 149).

How does the birthing posture affect birthing pain and women's understanding of themselves? Susan found that sitting or standing was much easier, in spite of the availability of the $9000 solid oak bed in her hospital birthing room. Christine had discussed the best position for labour with her doctor before the birth. He had said, "You should squat when you deliver, you shouldn't sit [referring here to the birthing chair]. There is a difference, because the birth canal is not straight down, it's curved. So you need to squat"(C3). But in her labour, Christine had only two choices, the delivery table or the birthing chair. Later when Christine discussed it with me, she said that she needed to say to her doctor, "If squatting is the way, how come you are not doing it?" And then she said, "Of course, they are not set up to handle it. You have to have someone to assist you, and they can't cope with that in hospital. So I presume that is why he doesn't do it. I should ask him"(C3).

Many hospitals allow only one support person to attend the labouring woman and do not have enough staff around to give the squatting woman the constant attention she needs. At home it was different as Anna described:

> Anyway, when I wanted to push, I tried in a forty-five degree angle sitting up, and that didn't seem to work and then Bill helped me get into a squatting position. I found that really good, and I had no trouble pushing—a very primal feeling. Cathy [a friend] and Frances [mother-in-law] came and got on either side of me and I could just kind of lean on them. (A4)

Finding a good position helps the woman to deal with the pain. Christine, who just recently had her second child found that this time she stood by the bed most of the time, enduring the contractions by slow controlled breathing, leaning on her hands, and slowly rocking her body through the pain. She was inward—her husband sat on a chair beside her. She did it herself, and said, "It was wonderful" (Christine, Personal Communication, March 2, 1986).

Space for Pain

There is not much tolerance for pain in everyday life. We try to remove pain as quickly as we can with drugs, with entertainment, with sex, with divorce, or with technology. Anna said:

> I don't think society allows us to deal with the harsher realities of life, and I don't think we are better off for it. . . . What we lose is the intensity of living—a vitality, the risk of being hurt or the risk of the responsibility of friendship and all that is involved in that. (A3)

But surely life should not be harsher. Surely, we have enough pain. Christine, Anna, Susan, Paula, and Jane described how the pain of birthing was important to their own personal growth, but, of course, they did not want to suffer pain unnecessarily. How can one experience necessary pain, like that of childbirth, so that it becomes an opportunity for growth and change? How can pain serve the process of transformation rather than debilitate or cause "residual maternal and psychological problems" which, according to Meinhardt & McCaffery (1983, p. 237), result from severe pain? How can the space in which women give birth aid them to transform their experience of pain into something useful for their lives?

One woman said, "The pain is powerful, overwhelming. I feared that I couldn't handle it. My anxieties related to how I would perform" (E). Susan, as well as Christine and Jane, wanted to be "good." "I was really worried that I was being really noisy. I didn't want to be yelling, and then it's hard to judge how loud you are" (S4). To be good means not to "make too much noise." It means to be "cooperative if one doesn't feel cooperative," and to not "make a scene." In their effort to be good, to please hospital staff, do women not act like children? In their effort to be good, do women not deny the potential they have to help themselves through the pain?

Being "At Home"

Susan and Jane gave birth in the birthing room, the new hospital structure which has been designed to humanize obstetrical care by providing a more comfortable environment. The birthing room concept allows for the woman to labour and deliver in the same room as opposed to moving from one room to another at the beginning of the birth itself. The birthing room is generally furnished with curtains, carpets, an easy chair, coffee table, telephone, television, and a bed. In this setting "parents are provided with the opportunity to discuss their preferences in relation to medication, treatments and potential intervention and become partners, with the nursing and medical staff, in the decision-making process" (Field, Campbell, & Buchan, 1985, pp. 1, 2). In the study by Field et al., parents indicated that what was satisfying about being in the birthing room was the privacy and the sense of control of their own birth experience (p. 137). They also found it comfortable, homelike, restful and helpful for relaxation. One often hears the term "home-like" in reference to the birthing room. Home-like is generally associated with the wallpaper, the rugs, and the softer decor. In spite of the obvious benefits that have resulted from the introduction of the birthing rooms, it is important to ask a deeper question about what the notion of a home-like environment has to do with the problem of childbirth pain? How does the environment of the birthing room affect a woman's experience of pain? How does it help her transformation to mother?

Does not the carpeted floor, the piped-in music, the bedside television, the handy telephone, sound more like a motel than a home? One then wonders whose home the home-like birthing room is like—the doctor's, the nurse's, the birthing woman's, or the traveller's? An exploration of the nature of "at homeness" (Baldursson, 1985) may be helpful. The Oxford English Dictionary (1971) defines home as "a dwelling place, one's proper abode; the place of one's dwelling and nurturing and the feelings associated with it; a place where one properly belongs, etc." (pp. 349-351). To be at home, is "to be at ease—in one's element, unconstrained and unembarrassed, familiar with things; accessible to callers; and so on." Do we not invite our guests "to make themselves at home," to be at ease, to be comfortable? We know the times we are "at home" in other people's home and when we do not. What is it that makes one feel at home? What does it mean to feel at home in a hospital?

Being oneself. To be at home is to be ourselves (Buckley, 1971, as quoted in Baldursson, 1985). To "be ourselves" requires no explanations, no guard against the misconceptions of others, no playing of "games," and no fear of abandonment. In such an environment, one does not worry about being good—in fact, one does not even think about the need to be good. At home we are who we truly are. We leave behind our public roles—as hairdresser, nurse, professor, office worker. We usually take off our work clothes, and get into our jeans—and we relate to our home mates as lover, friend, companion, or husband. We put our feet up, we have a bath, prepare meals, shave our legs, or make love. We do not need to excuse ourselves. Here we are at home.

Anna, because she had not had the "cleansing" enema, had to deal with the problem of "kind of pushing at both ends," which she described as her most embarrassing experience. "I felt kind of bad about that, but the midwives were really discreet about it" (A4). She did not feel rejected or frowned upon—just momentarily embarrassed. Paula, too, said, "I feel I rode the contractions in the sense of expressing what they felt like to me at the time—felt comfortable about being spontaneous in both vocal and physical reactions—being home felt right" (P2). Christine, on the other hand, said, "I can remember complaining that I didn't want to cooperate" (C3). Perhaps the question needs to be asked, what did it mean for Christine to feel that she needed to cooperate? If the woman is "at home" where she is the centre of the action, the central figure in the act of birthing her child, then the people surrounding her would need to be cooperating with her. The word "cooperate" tells us again that Christine deeply felt that she was dependent on others to make the various decisions with which she would need to cooperate. In a sense, then, one could think that Christine was not "at home"—was not being herself. Her resistance to what was done to her was expressed by a desire to "not cooperate" rather than do the things the way she wanted. "Unless the woman has some psychiatric disorder impairing her competence for decision making . . . she should have, as nearly as possible, the same degree of control over her activities and companions as she has in her own home" (Seiden, 1978, p. 101).

Having one's things. "Have you packed your bag?" There are lists of things that the woman should take to hospital to make her stay more comfortable. Essential materials are provided but she wants to bring her own things. During labour, however, personal things are put away. The hospital garb is provided which, as has already been discussed, helps the woman to fit into the patient role. The cups, the linen, the food, are institutionalized—"you can't bring it all in your suitcase!" I think back on Paula's birth experience. She had planned ahead—freezing the meal to be served after the birth, or letting her mother-in-law know what kind of tea she preferred—had prepared her home for this event. She had her own things. She drank her tea from "her" own cup. This special cup was made by a friend. It was a clay cup with the iron particles showing through the glaze. It was round and smooth, nice to hold. Her friend had molded this cup especially for her. During her labour, this cup, given with warm soothing tea, or with refreshing cool water, expressed the care and nourishment that Paula needed to be reminded of as she endured her trial. The cup, itself, ties her to her friends, and to the support that is needed to surround her during the pain. How different this cup is from the styrofoam cup that is used to bring a woman nourishment in the hospital.

Following One's Own Impulses

Much discussion has taken place around the notion of control. Many women talk of wanting to control the birth process. They want to be in control of their own experiences. In fact the emphasis of many childbirth classes is to teach women how to use breathing patterns, controlled relaxation, or prepare written birth plans, in order to maintain as much control as possible. Yet, one has to wonder if it is really control that is desired?

In one sense, to go with labour and its pain, one has to lose control to let the body do its work, to ride the wave of the pain. But how can one gain control by losing control? If women know they have control of their environment, they may be more free to abandon inner control, and follow the "out of control-ness" of their labouring body. In such a supportive environment women would be able to pick up "control" again when they choose (Morgan, 1984).

Although it may appear from this discussion that the home is thought to be the best place to birth a child, the home may not, in many situations, be a good place at all. What is important about this discussion, is that women need to feel comfortable enough (like they are when they are at home) so that their need to express their pain through change of position, having friends and family near, making noise, or receiving medication, is supported. The birthing room concept has the potential to provide such an environment—a place where women can truly be "at home" in the hospital.

Pain as Need for Community

Many women choose the hospital as the place for birth because they have come to see themselves as safe in that environment. The experts and technology are there if needed. They recognize their need for support. They need to know that they are doing well. They need support from partners, and friends as well as the experts.

Neumann (1955) and Briffault (1927) indicate that originally taboos initiated by women and imposed on themselves and men included the monthly "segregation" in the closed sacral precinct during their menstrual period. "Childbearing occurs in this same precinct, which is the natural, social, and psychological center of the female group, ruled over by the old, experienced women" (Neumann, p. 290). In that earlier culture the knowledge of the effect of herbs and fruits were used to soothe the pain. Even today women's knowledge and experience of childbirth pain helps a woman to face her own pain.

> I thought of the millions, literally billions of women who have experienced this pain, and if they could experience it, then I can too. That made me feel strong—that all women go through this." (A4)

Jane, too, took strength in the fact that other women have gone through and continue to go through this experience. The knowledge that women share with other women has been lost in the replacement of midwives by doctors (primarily male) as birth attendants. This loss is being recognized. The challenge by women to regain control of the childbirth process is a recognition of the importance of sharing the bodily knowing of childbirth with other women, as a mother would.

> My friend told me several times that I did well. Part of me wants to reject this because of the feeling that I wasn't controlled, I was lazy, I didn't perform ideally the way I imagined I would. Yet, overwhelmingly, I want to believe her and I do believe her. After all, I DID IT! It was hard. It was long. I did rely on my instincts. I did rely on my friends. In a very real sense, we did it together. After my first child, I felt, and continue to feel, that I'd always have an affinity with other women, unnamed but real. (P2)

> If women don't have a husband who took the time to know as much as Mike did—if they don't have somebody with them who really knows what's going on—how really, really vulnerable and devastating an experience it could be. (K3)

Another woman said, "I did need help, I really needed help. It gets to the point that you need help for really simple sorts of things." Such support must be there without the asking.

Support may take the form of back rubs, direct suggestions, sips of water, a cup of warm tea, a soothing touch, the words of encouragement, the presence of a caring person, the quiet of the room, and an acknowledgement that what is happening is what needs to happen. Women need to be reminded that the pain is there because this is the nature of birthing, not necessarily because something is wrong. "I can't begin to envision the nightmare and horror of carrying on (in the pain) without being in an atmosphere of caring and loving people" (P2).

While there needs to be direct verbal and physical support there needs to be recognition and respect for the privacy of the pain, as Paula said, "I especially appreciated everyone's silence while I rested on my side—I knew people were with me—there was never a doubt in my mind" (P2). Yet in this inwardness there is an attentiveness to the deep significance of the momentous quality of the pain. This is important pain, "a sacred fire." One woman said, "I was annoyed when someone was making light conversation with my husband. I felt it was disturbing and irrelevant to what was happening to me" (L). Another said, "I couldn't talk, didn't want to. In fact, I wanted to be alone at this point" (H).

> It was an incredible sensation being totally into myself. I didn't have thoughts. I was really in tune with my body. I think it must be something in you that just happens. In meditation you can go so far but this was much, much different. In those last few hours there was no straying of the mind. I couldn't talk because I was on one plane and he was on another. Mine was an inward focus. (V)

> I was aware that the midwife looked at me intensely and I couldn't bear to respond—I think my reaction was part of being inward—to respond would have removed me somewhat from what I was feeling. (P2)

This deeply felt experience reaches to the core and, as Buytendijk (1961) said, "throws us back on ourselves," demands women to muster up even more strength to survive, to live through it.

But not alone. "I look at Marie and I see the terror of childbirth in her eyes. I feel it. I remember it. I know it can be survived. I tell her so" (Harrison, 1982, p. 105). In aiding the labouring woman, one must recognize her autonomy and the reality of pain and difficulty, one must encourage her to use her special capacities to deal with the pain as a creative action of nature and not oppression (Kittay, 1983, p. 124). For example, comments like "perhaps you need a sedative," may lead to personal doubt and loss of confidence. Is it possible that the offer of medication to obliterate pain is sometimes accepted by a woman as it is the only support that is offered in the face of the overwhelming sensation of the pain? The offer of medication confirms the fear that, yes indeed, she will not be able to stand it. There is nothing else to do but suffer or be medicated. This is not to say that a woman does not need the help of medication—but the offer of medication (knowing its harmful potential for baby and mother) should not be the first or, indeed, the only support that is extended.

As the woman is surrounded by the deep sense of inwardness, she is forced to recognize her independence, her aloneness, her selfhood, to be conscious of her own existence. "I feel great for the process to have happened through my body, proud of realizing such stamina, strength, and determination"(V). The woman learns about the strengths she has—she has climbed a mountain—reached a summit. She recognizes her strength and capabilities in a new way and can say with Paula, "I can do anything now" (P1).

The Time of Pain

"And so it was, that, while they were there, the days were accomplished that she should be delivered" (Luke 2:6). It's time! Her time has come! The baby is coming! The pains tell the time. As the pains begin, women feel excitement. They also feel apprehension. This is what they've been waiting for. This is it! The pains are the knowing that the time has come. Yet, what is known? Women may know the stages of labour, know the procedures to expect, know some things to do, and yet ask, "How will I handle it? What will it *really* be like? Each time, we know more about what to expect and do, but the mystery of *this* time is still present. Each time is its own time.

Rhythm

"It is a different kind of pain—like muscle cramps or extremely bad gas—comes and goes—that is the reward—that it goes away" (J3). Further exploration of the etymology of the word "birth," shows that "to bear children" is tied to the root bara (Old Norse), meaning wave, billow, or bore. "Bore" is defined as "a high and often dangerous wave caused by the surge of a flood tide upstream in a narrowing estuary or by colliding tidal currents. "This wave imagery is closely associated with the idea of rhythm. . . . With each wave of the sea the tide gradually flows farther in, bringing nearer the time when her baby will be in her arms" (Kitzinger, 1979, p. 85). We can have with the pain wave of birthing a sense of being carried by the pain as we ride with it, by being caught by the pain and enduring it, or by being overwhelmed by the power of the pain that "throws us upon the beach only to pull us out again to sea." The contractions of birthing, like the colliding of the tidal currents, are most painful at the point in the process when the baby moves down the "narrow estuary" of the birth canal. Birth, as wave, tells us about the coming and going of the pain, the developing intensity, the climax, the release, and the moment of gathering resources for the next coming of the pain wave.

When women talk about the time of labour, they think of timing the contractions:

> And then about 9:30 p.m. I was thinking about my pains and noticed that one was coming from the back. I began to think I was in labour. We started to time them, 7 minutes, 10 minutes, and then about 10:30 they went to about 4 minutes, lasting about 30 or 60 seconds. It wasn't hard for me. (C3)
>
> When I first went into labour it was about midnight—about 5 minutes apart, these funny twinges. (S3)
>
> On Monday night I felt twinges, menstrual cramps—then the next day they were 10 minutes apart and about 30 seconds long. (A4)
>
> Taking out our little brown spiral notebook which I had bought two days earlier, small enough to fit in a shirt pocket, he wrote down the time and duration of the contraction. He had a digital watch and used the lap counter, as if he were running. (Israeloff, 1982, p. 86)

The timing of the contractions gives helpful hints as to what is happening, for we know that as the pains get longer and stronger the farther into labour the woman has progressed. Yet even this timing can be overdone, with pages of records of contractions, for after a point, most women know themselves the nature of their contractions. The more women are assisted to recognize their own body rhythm—they may be able to flow with its pain in the process of birthing their children.

It Would Never End

"It was as if the pain was all there was. It would never end. There would be no result. I would live it forever (P2). During labour there is no sense of growth and change but the cessation of time. There is no intention, only the will to endure. "I only know that I have been lying in this pain, concentrating on staying above it, for a long time because the hands on the clock say so, or the sun on the wall has moved to the other side of the room" (Young, 1984, p. 54).

A New Beginning

> And then I couldn't believe the sensation because—it was—as soon as I saw him, it was as if everything was gone and it gets very blurry." (S4)

> I couldn't take my eyes off him. I cut the cord. That was really cutting the cord, really making the break from the baby. It's one relationship—then he is born— that relationship dies and another relationship begins. (V)

Deliver, deliverance, the act of transferring to another. The pains are a literal expression of the narrow gateway leading to release in the expanse of life. The involvement changes from the self-as-world to baby-as-world. As the body releases the baby, the pain is released. The attention is turned to the new life, the new being.

> When Joanna was placed on my tummy, I almost felt as if I couldn't react . . . as if I was slowly emerging from a situation of being purely reactive to what was over-whelming me (the pain) to coming back to "me" in all senses (the intellectual, the person others know, the daily self). In a way I was numbed and had to slowly make my way back into the world. (P2)

> Something in me was released. I turned away from my somewhat egotistic involvement in my labour toward my child, since that moment my love has grown so that . . . it actually hurts sometimes. (Kitzinger, 1971, p. 161)

The pain is released, with the possibility of a new and different pain tied to the incredible and awesome awareness of a separate being. The woman who becomes mother vastly increases her capacity for pain and vulnerability.

"Being born into motherhood is the sharpest pain I've ever known" (Chesler, 1979, p. 281). With the pain of childbirth women become mothers. Can pain be transformed into something usable, asked Rich (1976, p. 151), "something which takes us beyond the limits of our experience itself—into a further grasp of the essentials of life and the possibilities within us?" What is it that is learned?

> I think I have a right to feel good about myself. In a way, this birth is helping me to accept myself—both the limitations and the capabilities. Accepting myself is the other side of the coin of accepting the pain. I need to think further about it but have a sense that, for me, *this* has considerable significance. (P2)

> I would never have wanted it any other way. It gave me confidence and strength. I was able to deal with the pain, to confront and overcome. Now I know that I can deal with it—and that is useful in encountering other painful things. Of course, not all pain has a silver-lining—like the babe. (A6)

To have experienced birthing pain offers the possibilities of self knowledge, knowledge of limitations and capabilites, knowledge of new life as mother, and of a woman's place in the mysterious cycle of human life: birth, death, and rebirth. As women give birth to children, they, in a sense, birth themselves. They become mothers, like their own mothers, and as their daughters will after them.

> There is that sisterhood. There is a knowing that you, as a mother, have gone through what I've gone through. Men haven't gone through that—even though they participated as much as they could have. (A5)

Victoria said, "Rose was the only other mother there. I had something in common with her. I started to cry when she hugged me" (V).

Chapter 7

ONE FOR ANOTHER: THE TRANSFORMATIVE SENSE OF RESPONSIBILITY

The Meaning of Responsibility

To become a mother involves responsibility, responsibility for the birth and life of another person, the child. It can feel like an overwhelming responsibility—a terrifying one—especially when something goes wrong. An incident sticks in my mind from when my son was small. He was younger than four—sick with a cold or flu—his fever was rising. I felt his forehead, soothed his restlessness, wondered what to do. My "nurse" hand moved to his pulse—a jolt went through me—his pulse was rapid and erratic, fitful, all over the place! What did this mean? Oh, No! Was something wrong with his heart? How did that happen? What can I do now?

We talk about taking responsibility for ourselves, and for the child, like Anna did during pregnancy, but when there is an actual child in your life, your child, a child entrusted to you, (and even the child as stranger) who is not breathing properly, who has an erratic heart beat, who is heard crying amidst the rubble of an earthquake, we are transformed by a sense of responsibility that subjects us to a certain terror that is not present in talk. Christine felt it early when she found herself bleeding, and Susan, too, when she thought her pregnancy might be tubal (the fertilized ovum implanted in the fallopian tube which would mean surgery and the loss of her "baby"). And when Jena did not respond immediately at her birth, Bill had a sense of panic with the recognition that, "Oh, my gosh, is this what having a kid is like? Terror like this? Will she be okay? Will she be okay tomorrow? Will she be okay the day after" (A4)?

We are shocked by our helplessness as we come face to face with the reality of illness, deformity, or death of the child we accepted in our life. "It took the wind right out of our sails," said the father of a two year old boy who needed chemotherapy treatment or would die. "We want to take the pain and the treatment for him." Other parents say they would die that their child might live. What leads to a sense of responsibility that has such profound dimensions? Is this what having a child is like?

Thinking of responsibility in relation to becoming mother, the following statement does not seem so strange, "Oh, yes we are finding baby furniture now, preparing, getting ready . . . and there is preparation for death too. Are they really so different" (Woodman, 1985, p. 140)? As we prepare for a child in our life, we prepare to accept that something can go wrong. We are forced to imagine the death of our child. We are forced to face our own mortality. As we begin to acknowledge our own death our thoughts come back to the child for whom we are responsible. Do I ever think of dying? Only in terms of who will mother my children. But then, how does one think of dying? One can only really think of living. Dying is too far away, or too close. "Who will mother my children?" A child needs a mother. In thoughts of death are we not reminded of life, of how we should live? In being responsive to our child and his or her life, are we not thrown into a renewed attention to how we should live? What has been a self-regulated, self-defined, and self-contained life is now suddenly broken by the experience of the Other, the child. And in taking responsibility for the child, as Other, we are forced to be responsible also for ourselves. About a month before Keith's birth, Susan talked of her concern about Paul being away on a skiing trip which had never bothered her before. Now she says, "This child needs a father"(S2)! Or one can think of the father who stops drinking coffee to protect his heart, "I need to live at least until the boys are old enough to look after themselves." Even when Christine thinks of the possibility of the death of her baby, or her husband (given a choice), it is her son that should live (C7).

For a woman becoming a mother, this responsibility starts early. Even before she knew for sure that she was pregnant, Katherine said, "I shouldn't be drinking now. It would be an inappropriate thing to do" (K1). In response to the baby they carry, women are subject to self-denial. Is this responsiveness not really a transformed experience of responsibility for the Other, the child? Can we get a clue from the origin of the word "responsibility?" "Responsible" comes from the Latin *respondēre*, "to promise in return." As we respond to the presence of the child, then, we promise to look after that child; to be trusted by the child, to care for the child. No longer are we acting only for ourselves—we are "one for the other" (Olson, 1986). It is an awesome project.

A child needs a mother. By being responsive to a child in her life, as Other, a woman becomes a mother. Yet, in that responsiveness there is a problem in living one's life solely for one's child. Remember Christine talking about women who seem to have lost themselves. "Everything is for their children or someone else and not for them" (C1). Here is a crunch, an ambivalence. How does a woman become responsible as a mother? How does a woman come to live as mother—for her child—and yet be herself? How does a woman act responsively toward the child in her life, and yet be true to herself and her own project of living? Does it mean that a woman gives her body to the care of others during pregnancy? Does it mean that a woman's own experience of giving birth is secondary to the experience of birth for the child? Does it mean that a woman should stop working and devote herself to the care of her child full-time? Does it mean that a woman should stop being in relation to other adults on a daily basis?

The situation of women in patriarchal societies complicates the matter further. Women are the "other"—like children, like blacks, like the aged, even like the poor. But here the notion of *other* is not that of the "real" Other, the child, which both women and men come to accept in parenthood. When writers like de Beauvoir, Daly, and O'Brien speak of women as "other," they remind us that women live in a world focussed on the norm of the male body (not subject to the cyclical nature of menstruation), the male-dominated public decision-making bureaucracy (which venerates objectivity, management, control and efficiency), and the male-dominated health care establishment (in terms of prestige and power).

For many women facing the responsibility of the child, the move to mother in the economic, political, and social sphere can be either empowering or disenfranchising—and in some sense, may be both. At the same time as a woman may feel blessed by a child in her life, by the very fact she is a mother, she may be even more oppressed. Poverty, lack of employment opportunities, lack of parenting support services such as flexible work hours, child care, or even financial assistance, make the endless tasks that are involved in caring for the young child very difficult. So for women, while they move toward a responsibility that transforms (in their responsiveness to the positive "other," the child), they are continually faced with the reality of their own "other"-ness (a negative reality) in our patriarchal culture. Therefore, in exploring the theme of responsibility the focus becomes divided: responsibility for the baby, and responsibility for the woman. Should not both be considered? What is best for the baby cannot be overlooked, but what is good for the woman must also be kept in mind. In the effort to see the baby as central, there is the danger of losing oneself. As we realize our responsibility to the baby the experience of self becomes blurred.

Time to Take Responsibility

Looking After Oneself as Looking After the Baby

To have a healthy baby, the pregnant woman must be healthy. She is told by everyone, doctors, nurses, family and friends, that she now must look after herself. As soon as she is pregnant, or even before, the woman is encouraged to eat right, avoid alcohol, tobacco, drugs, and even coffee. She is encouraged to get enough sleep, enough exercise, and enough fresh air. She is warned against micro-waves, computer monitors, X-rays, ultrasound, too much exercise, and even "You shouldn't lift things over your head" (B1). With the increasing information, women are becoming more conscious of the association between environmental and substance toxins, and fetal abnormalities. They are aware that their responsibility tends to come earlier and earlier, even before there may be any experience of pregnancy. Pre-conception information supports that early responsiveness on the part of women.

So women look after themselves, in a way they did not before pregnancy. When Christine found out that her blood pressure was fluctuating she realized that she had to slow down.

> I'm more conscious of the pace, how I go through my day. If I am tired—well, I don't do the two other things I planned. I do what I have to do but I don't do the extra. I needed to be made aware of that—pay attention to my body. (C1)

Some women may find it easier to quit smoking when there is "someone else" to think about. Yet, some may not. They may become more responsive, and responsible, once they are convinced that there is in fact a baby present. When they feel the movement, hear the heartbeat, and see the kicks and rumbles across their stomachs, they begin to sense the reality of the baby. For some the ultrasound makes the baby's presence more real. "I had an ultrasound at eleven weeks. The baby was all there. Whole. It came real to me because of that. I didn't feel pregnant. It brought everything into focus" (C1).

Perhaps those women who do not stop smoking or drinking have not yet been transformed by that sense of responsibility for the child. This may seem like a simplistic notion but it may be that women have not yet realized or believed that the child, as a separate being (but not independent), can truly be affected by their own actions. Is the "it cannot happen to me," another way of avoiding responsibility? All the women in this study stopped drinking, watched their diet, and avoided "smoking environments" during pregnancy. They were doing this for their child, although Brenda talked about doing it for herself too. She said, "I figure that I have to look after this child so if it is healthy and happy it will be a lot easier" (B1).

But "taking care" may not be enough. The increasing number of technological investigations, such as amniocentesis and ultrasound, are constant reminders that in spite of their care of themselves women may bear a baby with congenital disease and handicaps, or that they themselves may develop high blood pressure, toxemia or other diseases of pregnancy which could threaten their baby and themselves. Although Susan faithfully ate her "veggies," as she said, she was still afraid that her body would let her down, and her baby would not make it. Anna too, looked after herself with care, but worried about the possibility of a deformed child, "I don't know how I would deal with it—living with a child that has mental or physical problems on a day to day basis" (A1).

Susan had always had it in her mind to have a baby. In spite of the decision that now was the time, Susan did not conceive after trying for over two years. She and Paul applied to adopt a child. They decided to bring "any" child into the space they had opened for "their" child. Therefore, it came as a surprise for Susan to become pregnant. But she was cautious. She did not trust her body and dared not be too open to this child. "I have not bought any baby clothes, or that kind of stuff. I have been prepared for the worst that I sort of don't want to push it. It is too early, like it is going to be jinxed" (S1). She even saw "the little heart beating," through ultrasound at eleven weeks, and had felt the baby move, but still held back. "The worst" might still happen. So Susan, at the same time as she wanted a child in her life, would not let herself really be at ease in accepting the reality of "this" child. It was not until the eighth month that the space for the baby in the house was ready. Now she could say, "Yeah, I've got the curtains done and I've got the quilt-cover done, and the crib is painted. You see if worse came to worse and I delivered the baby now, there's a pretty good chance that, you know, things could be okay. And so I feel a little more like going and looking for baby things" (S2). Although women have a sense of their own responsibility in creating a healthy baby, there is also the realization that there are things about having a baby that are beyond their control.

Getting Things Ready

As women get closer to the time of birth many begin to feel their responsibility to get things ready—the baby's clothes, the baby's room—and they also get ready for their own labour experience. They pack their bag. And in their bag they may have a Birth Plan that they have worked out with the doctor. They have chosen the person, usually the child's father or a close woman friend, to be with them. They are ready.

When Anna talked of taking the responsibility for the birth she described how she had sterilized the towels and sheets, how she had purchased the protective sheet for the bed, and even, early on, how she had found a place to live that would accommodate the home birth. She said, "It was almost a ritual to sterilize the towels and things. It was good to do that because to a certain extent you're overwhelmed by the responsibility. I don't think I would encounter that if all I did was to pack a bag and go to the door of the hospital. It is a different kind of preparation" (A2). The actual physical preparation (sterilizing the towels and purchasing the pads) helped Anna to prepare to take the responsibility for giving birth.

Anna was the only mother in this study who talked about the possibility of the death of her child during labour and delivery. It was central to her story. Of course, this is understandable as she had chosen to birth her child outside the bounds of "approved" practice. Thus she was open to all the "what if" questions that hospital care is presumed to deflect. Anna said, "I have thought of the potential of—let's say the baby doesn't make it. If it [the birth] is in the the hospital everyone would say that the doctor tried his very best, but if that happened at home, we are going to be seen as irresponsible—as killers, or murderers" (A1). Then she said, "I think that for us a birth at home is less of a risk than the hospital. I think people do not want to believe that it is safer at home because they want to put the responsibility into the hands of the doctor and the hospital." Anna would say, then, that having the baby at home, and getting things ready for the birth, helped her to move to motherhood through accepting responsibility for herself and her child in a way that she could not if she had planned to go to hospital. Of course, she said that she would go to hospital if necessary, but would prefer to stay home.

The women were ready when the time came. The frequent trips to the bathroom, the difficulty in moving around easily, the need to eat small, more frequent meals, the finding a comfortable position for sleep, all made each woman ready.

> Now the baby has filled up the space, very tight,—is lopsided sometimes—with head and foot sticking out. (C2)

> I'm feeling more discomfort. You know, up until Christmas it was easy. But since then, I've been feeling more and more sluggish and slow. I guess if you felt wonderful until the end you wouldn't care if you had the baby out or not. But, you know, whenever it is ready to come out, I'm ready. (S3)

But what does it mean to be ready? While Susan thinks it is time for the birth, that her body is ready, she also wonders about her readiness in another sense.

> Gee, am I ready for this? I am going to be 32, I'd better be ready. When are you going to be ready. I think as soon as we have the baby I'll feel like—I think it's like starting any new job, you know, I didn't feel like a teacher until I started doing it." (S3)

Embodied Responsibility

We are made ready by experiencing the responsibility through our body. Many of the women were aware of their pregnancy before they knew "for sure" from a pregnancy test, or the doctor's examination. Christine was so sure that in spite of the fact that the pregnancy test was negative she said to her doctor, "Treat me as if I am because I am" (C1). Katherine was also sure, so didn't need a pregnancy kit that contained two tests. One would do. Susan, on the other hand, had lost faith in her body, was fed up with her body not doing things right so did not consider her very sore breasts—so uncomfortable that she had a hard time walking up and down stairs—as a possibility of pregnancy. Women depend on the doctor's examination for confirmation. Dependency on the pregnancy test, the doctor's examination, or other technological tests, such as ultrasound, has the potentiality of devaluing women's own body-knowledge.

During labour this attitude can be especially problematic. A pregnant woman feels the contractions of her uterus, and the movements of the baby, with an immediacy and certainty that no one else can share, but with increasing use of techniques and machines such as ultrasound and fetal monitoring, her experiential knowledge is reduced in value, replaced by what is seen as more reliable knowledge. As devalued knowledge it is easy for a woman to lose touch with or doubt her own experience, and to accept objective knowledge as more correct and therefore valuable (see Chapter 9).

Body as Beyond Control

Menstruation is the first sign that reminds women, and society, that complete control of female bodies is not possible, and may be the reason why it is viewed so negatively by a society which, above all else, venerates control (Martel & Peterat, 1985). This desire to control is so entrenched that the "sign" of menstruation is denegrated in the effort to control it. In pregnancy, the woman shares her body with the growing child, an experience bound by fatigue, weight gain, nausea, flatulence, shortness of breath, vulnerability, and clumsiness that can be only partially controlled. In fact, these uncomfortable bodily experiences are a part of a healthy pregnant woman's experience. Labour has been defined as stages in an effort to manage and predict but each woman's labour has its own rhythm, pattern and progression that left alone passes in its own time. The baby, too, with a rhythm all its own, demands that time move with its pace ("fetal time" as it is called by Rapp, 1984, p. 314). The effort to control, for example, to control death, creates dilemmas that now confront us, like the "right to die," which might be equally as important as to "live at all costs" (McDermott, 1986).

Humility, the virtue needed to take on a world beyond our control "emerges from maternal practices and accepts not only the facts of damage and death, but also the facts of the independent and uncontrollable, developing and increasingly separate existences of the lives it seeks to preserve" (Ruddick, 1983, p. 217). Humility, when confused with self-effacement (humility's degenerative form), is a negative image that mothers and society abhor. Nevertheless, true humility, developed in face of the circumstances of life's uncontrollable situations, is a characteristic to be treasured. Faith in women's bodies gives power, not power "over" but power to "go with," to move within the forces of body knowledge. Such faith gives women the confidence needed to take charge of their own environments which would allow for freedom to live lives autonomously, making individual choices in line with their own sense of values (Kitzinger, 1975). Women who mother are transformed by the recognition that complete control of life, as the control of death, is an illusion (Greer, 1985, p. 18).

Obstetrical science does not easily place itself in a humble relationship to the reality of the mystery of life, and those aspects that are out of human control. In the effort to control and manage life (and death) there is the potential of usurping women's need to develop their own sense of responsibility that giving birth entails. Brenda's husband's wish for a Cesarean birth gives a clue to the problem that is faced by women. Brenda said, "Now he wants me ~~to have a Cesarean~~ so he could watch them take it out from the other side. He says it is more humane, like he didn't like to have the woman suffer" (B2). While it is important to control suffering, there is also a need to consider that the challenge faced by women in childbirth may have some value.

Cesarean Births

Close to one out of every five births in Canada and the United States now occurs by Cesarean section (Elkins, 1982, p. 2; Cohen & Estner, 1983, p. 9; Brackbill et al.,1984, p. 23). There are situations in which the Cesarean birth is necessary to save the life of the baby or woman, such as maternal pelvic contraction, prolapse of the cord, and haemorrhagic conditions (Cohen & Estner, 1983). There are other situations in which Cesarean sections are not so easily justifiable, such as dystocia, prior Cesarean delivery and breech presentation. With the declining birth rate, and the fact that many women wait longer before having a baby, the perfect baby is sought as never before. Some women and doctors expect that the Cesarean birth insures the greater probability of having the "perfect" baby and almost always the Cesarean section is done on behalf of the child (Brackbill et al., 1984, p. 23-25). "When it's an older woman and there is a chance that this is the only child she will have, you want to make sure it is alive and well. So I call a halt to the risk taking much earlier through surgical intervention," said one doctor (Fabe & Wikler, 1979, p. 287). This means that the "risk-taking" of the vaginal birth is being brought under the control of obstetrical management by surgical intervention. The "out-of-control-ness" of women's bodies is devalued in search of perfection. Obstetrical science and technology are thought to be more reliable and predictable than the vaginal process of giving birth. Here, control of the natural process is dominant. No thought is given to the woman's need to birth the child through her body. No thought is given to the process of birth as a valuable, and perhaps essential, part of a woman's transformation to mother. Concerns raised in this wa about Cesarean births do not disregard the fact that some babies or mothers may need this intervention. Rather, the concern is raised to question the notion that surgical intervention is a better way to birth.

Katherine (like other Cesarean-birth mothers describe in Cohen & Estner, 1983) spoke of the disappointment and guilt she had about her Cesarean delivery. Katherine said to Brett, her baby, many times, "I'm sorry kid, that it happened like that" (K4). Katherine talked of her sadness and the real sense of the inadequacy in her body, that her "body let her down." Another woman may say, "what did I do wrong?" The woman may feel that it has to do with the lack of "bonding-time" (especially with general anesthesia), or of being denied the opportunity to see and hear the baby right away. She may wonder if the disappointment comes from missing the feeling of the baby moving out of her own body. In contrast to these voices, Jane said that her acceptance of responsibility had partly to do with the birth itself, "I suppose part of it is working towards having the baby—doing all that hard work—and then seeing this baby come out of your own body in birth. It was seeing her" (J3). The actual birthing experience, the labour itself, may be important to women. Maybe it is seeing the "whole picture" as Katherine said (K3). She wants to find out what really happened. She wants to see what the obstetrician wrote on her chart. She wants to see what her baby was like at birth (e.g., the Apgar score). She wants, in a sense, to relive the birth. The birth process, her labour, is important for her own understanding of herself as mother.

The desire to control nature is not new. To control nature, to try to improve on women's ability to deliver babies vaginally, is the expected result of the never-ending search to control life.

Think back on an earlier example in this work regarding the practice of separating infants and mothers at birth. Although some women wanted babies with them, it was not until there was scientific "proof" of the value of those initial hours that the "natural" was supported by scientific evidence and practices changed. At the present time, a woman like Brenda who is not able, for whatever reason, to look at or reach for her baby at birth, is observed by the staff as a concern to be "noted on the chart" (according to the nurse-midwife). Prior to the scientific research on bonding, Brenda's reaction would have not been thought significant. Will scientific studies be needed to convince the obstetrical surgeons that the vaginal birth is a better way for living as humans for both mothers, and babies? In spite of scientific medicine's impact on mortality rates and heroic life-saving practices, vaginal birth may be important and needs to be considered. In fact, it is precisely because the mortality rates have decreased that attention can be paid to the practices in childbirth in terms of what is right and good for our humanity, and what is right and good for women in their project of giving birth and becoming mothers.

In the effort to control nature for the perfect baby, what may be bypassed is the quality of life (the whole picture). The whole picture is one that includes mother and child. The mother's realization and acknowledgement of the strength and power of her reproductive body is realized in her ability to birth her own child. What may be lost in bypassing this event is the experience that completes the reproductive cycle. Pregnancy and birth is likened to the progression and intensity of sexual pleasure in intercourse. What happens when women miss the orgasm, the release, that leads to satisfaction and contentment? What happens to women like Katherine who grieve because their bodies let them down? How do they work through their sadness so that they need not feel guilty about a process that was out of their control? The embodied experience of "giving" birth enables women to learn to take the responsibility for the child that may be missed in Cesarean deliveries.

Space for Responsibility to Develop

The Place of Birth

Today much discussion about childbirth focusses on the place of birth. As was pointed out in Chapter 1, for most women and medical personnel the hospital is the preferred location, primarily because of the proximity to life-saving expertise and machines. Women feel they are taking responsible action by following this trend. They do not wish to take a chance. Yet some women are beginning to realize that the hospital environment may not be the most favorable place for this intimate event to take place. Christine and Brenda delivered in the traditional labour and delivery room system, while Jane and Susan delivered in a birthing room. Both Anna and Katherine chose to deliver their babies at home. Anna and Katherine felt that a home birth offered the opportunity for them to act on their own good judgement rather than under the authority of others, such as the doctor and hospital staff. The issue is not the question of safety: both women felt they were making choices, based on the literature, that with a normal birth, the home is as safe, or even safer, than a hospital (Mehl, Peterson, Whitt, & Harves, 1977; Hoff & Scneiderman, 1985).

All the women spoke of childbirth as a normal, natural event. Up until the time of the birth all took responsibility for themselves—they watched their nutrition, they exercised, they went for their regular checkups, and they took prenatal classes. Yet most women chose a place of birth in which they would be safe in the hands of others. Of course, it may be that in our present maternal health care environment the hospital is the most appropriate choice for some women but not for others. What is important about the place of birth? What does choosing a place of birth have to do with responsibility? Katherine hints at this problem as she described her move from home to hospital during labour:

> When I went into hospital things really changed for me in the sense that all of a sudden there were a lot of things done to me. I was a patient. It was a real change—a turning point. From then on things were really out of my hands. (K3)

"Things were out of her hands"—she was no longer in control. Did this mean she was no longer responsible? Whose hands was she in?

Hospital Space: "They did a lot to me"

When I visited Brenda in the hospital the day after the birth I was reminded of the fact that, although I was visiting her, both of us were visitors in the hospital. Brenda sat on "her" bed in a room with two or three other women. Suzie, her new baby daughter, was sleeping in a plastic bassinet at her side. Brenda felt well and talked about going home. She did not like the hospital—the bed, the place, the noise, the babies crying and the things that kept them busy. She wondered about her husband, how he was and what he was doing. She was not "at home" in the hospital. It is a foreign space, someone else is in charge. In such an environment it becomes easily possible for "them" to do things to "you."

The rituals that occur in the hospital environment demonstrate how responsibility shifts from personal autonomy of the woman to authority and responsibility centered in the hospital staff and hospital routine (Kelpin & Martel, 1984). Christine said, "You know, I was pre-admitted" (C3) which means that as a pregnant woman, under the care of a doctor with hospital privileges, she is recognized as someone who should be granted admission. Etymologically, "hospital" is a doublet of "hotel" and the words presuppose that someone enters into a "hospitable" place, as a guest or a hostess. The hospital, as we know it, is the place where sick people enter in order to be restored to health or to die. Christine, the birthgiving, healthy, pregnant woman also entered the hospital.

> You know what struck me [talks hesitantly] when you go through admitting, they are, uh, your name, number—("Don't you know I'm in labour!) It was so routine to them. The admitting was quite long, and I was getting quite uncomfortable, and I needed to lie down or something—and them asking for my social insurance number. I had forgotten it, and now 'what do I do?' I just remember thinking that this must be very boring for them, this routine business. (C3)

Christine speaks of "routine business," of "numbers," and of the "boredom" of admitting staff. The exciting reality of labour for the woman, and the formal and routine reception of entering the hospital, were at odds. A wheelchair was brought down from the ward for Christine. "Did they think I needed a wheelchair?" she thought. Although not used, the presence of the wheelchair was a symbol of incapacity and a reminder that she was in place for the weak, sick, and needy.

Next, Christine was taken "up to the ward." The word "ward" comes from the Anglo-Saxon *weardian*, meaning "to fend off, to keep from hitting, to turn aside anything mischievous that approaches." To be taken "up to the ward" literally means to be brought under guard in confinement or custody, to be brought up to protection. The ward is the perfect place to depend on others. She said:

> Then things happened really fast, they did a lot to me. I can't tell you a lot of the things that happened between arrival and getting into bed. It's vague—I was really intent on lying down. I wanted to get into bed and to get relaxed. (C3)

Activity was all around her but she just wanted to relax. Christine's words display the gap between what she wanted to experience, that is, the relaxing of her body, and what was seen as necessary for her admission to hospital. Her concentration was focussed inward while the admission procedures forced her attention outward.

Her world on the ward becomes the world of the "they." They are the anonymous people, nurses whose names and faces she could not remember. They were introduced to her but she could not remember who they were. As her attention was turned inward the people around her remained faceless and her surroundings remained vague. "It was a quiet room," said Christine, "I thought that was fine. It was fine for me to be by myself with my husband, or with them. I can remember getting the gown on. There were several nurses involved" (C3). Attired according to the status of a patient, Christine entered further into the world of medicine (of passivity and obedience). Her gratefulness at being in a quiet room alone with her husband shows Christine's underlying desire for autonomy, or independence in an environment which would support her need for relaxation and inward attention.

The statement "they did a lot to me" shows a passivity suitable to patienthood on the ward. Like Katherine, Christine was becoming a "patient," from the Latin *patī*, "to suffer" as one who patiently waits upon the initiative of others who know what needs to be done. From the healthy condition of life giving, she is transformed into the recipient of care within the enclosure and procedures of the hospital ward. Becoming a patient meant that she had lost her autonomy as an independent healthy person, and gained dependence upon the medical community. What does this move to patienthood do to her own sense of responsibility?

Does the use of a birthing room change this gradual assimilation into the hospital environment, and the "patienthood" that Christine and Katherine experienced? Susan and Jane used the birthing room. Both found it pleasant. Of course, so did Christine, for that matter. But here the attempt is to understand how women are transformed by the responsibility that becoming a mother entails, and how the environment for the birthing supports or hinders that process.

The staff, at the hospital where Susan birthed, left her and her husband, Paul, alone much of the time during labour, after checking the fetal heart with the stethoscope. Susan's main concern, during labour, was that she did not make too much noise. She wanted to fit in without a fuss. The staff were supportive and gave her ice water for her dry mouth, Demerol for her pain (which did not relieve the pain but made her dozy and distant from it), and helped her find comfortable positions for labour. The fetal monitor was not used. In the end, Susan needed the help of forceps to bring the baby's head over the lip of the cervix which would not retract. The staff were there to help Susan and seemed to consider her wishes (for example, delaying the rupture of the membranes), and Susan was grateful for the care they gave her. The five days she spent in hospital went quickly. It was a busy time. "By the time you fit yourself around the hospital's schedule—breakfast at a certain time, and then exercises, and then the baby is brought in to be bathed and fed—there is not much time left" (S4).

Jane arrived at the hospital about two hours before Lisa's birth, and was pleased that the birthing room became available to her. "It was great," she said, "It was carpeted and there was music playing, with a little television beside the bed, and a telephone near" (J3). She was put on the fetal monitor right away, and once her membranes had been ruptured by the resident doctor, the external apparatus was replaced with internal electrodes. Jane thought the membranes were ruptured because they were so busy, they needed the room, and "didn't want me to take any more time than I had to." The nurses and doctors were helpful, giving directions to guide the birth.

> All of a sudden, in the middle of a contraction, I had to push. They said, "Don't push, don't push." I could breath through those all right. My doctor was still not there, so the resident came back in and scrubbed, and got all dressed up, and kept saying, "Don't push, don't push." Then my doctor arrived and I was told to, "Breathe, breathe," until he was ready. So by the time I was allowed to push, I was really ready to push. Jim was really my saving grace, as he kept saying, "Don't push, breathe." He kept me on track. Even then, when I got pushing, they wanted me to stop so they could do an episiotomy. That was really tough. When she came out I was really amazed, she was so tiny yet she looked so big. The head looks incredible. It was just more awe inspiring than anything. The doctor held her up, before they cut the cord, and said, "Look, don't touch, but look at her." And we looked at her. (J3)

Jim was Jane's saving grace—keeping her on track according to the directions and wishes of the doctors and nursing staff. Jane was only "allowed" to push when they were ready. Her labour had progressed normally throughout as she followed the rhythm of her labouring body in a supportive environment of her husband and parents. When she went to the hospital and moved toward birth (in the birthing room), she was told what to do so that the staff and their procedures could be accommodated—the waiting for the doctor, the scrubbing, the dressing, the episiotomy. Now, she needed to be "kept on track," to look but not touch and to be "saved" by others. Has the birthing room really enabled women to gain access to life-saving capabilities of medical science without being deprived of their own life-giving prerogatives? In whose hands was this birth?

Home Space: "We did It Ourselves"

When I visited Anna, the day after the birth of Jena, another situation was evident. Anna, and Jena (the new baby), along with Anna's sister Carol and her two year old daughter, Nicky, were together in their living room. Nicky held the baby. Anna served me coffee. A short time later, Bill arrived with a big box of diapers. They were at home. I was the guest.

By virtue of it being their home, their space, they were in control. By being in control of their space, they were able to allow the birth process to proceed in its own time. Anna felt she was in control most of the time during her labour (although she nearly "lost it" in transition). Yet during the labour itself one really expects to lose control—the contractions of the uterus, the pain, the intensity take over, take charge—and by going with it, in a sense by losing control, one gains control.

> I was in my body . . . I was somewhere on the ceiling, out of reach, out of hearing. My thoughts were in one place, my body in another. (Chesler, 1979, p. 255)

"The midwives were incredible," said Bill, "they were so unobtrusive. They didn't do a lot during labour, they were so patient. It was wonderful to have them here—to check the fetal heart—but because we were managing, they stayed in the background" (A4). Bill goes on to say, "We did it ourselves," which is what, I think, women want when they say they want control. They want to do it themselves, they want autonomy without losing the support of others. Bill's remark differs substantially from the misguided sense of responsibility exemplified in the doctor's comment to

Christine after her birth, "I don't want you to do that to me again" (C3). Although Christine had maintained control of herself to the best of her ability, she was held responsible for the difficult labour (after being subtly subdued into patienthood and thus denied personal autonomy).

In the hospital it is easy for the doctors, the nurses, and others to take responsibility: It is their space. At home, although the midwives were there, the responsibility falls on the mother (parents): It is their space. No matter how the hospital rooms are "dolled up" (Anna's term) with the cozy quilt, the rocking chair, and the telephone, the home-like hospital is still a strange place, a foreign space—"might as well have the green walls and the harsh lights," said Anna (A6). A foreign space, by the very fact that it is not home, creates a problem of control, of "whose hands it is in." Yet again, perhaps it is not control at all that is desired, rather autonomy—the difference is a tricky one. Even in the birthing room there is a need for staff to relinquish control so that a woman can be free to follow the biological capacities of her birthing body, which contains the right to "go with" rather than "control" the birthing process. "For a woman to attain autonomy she need not renounce her biological capacities, but gain control over them" (Kittay, 1984, p. 133). In gaining control she has the opportunity to relinquish her control to the autonomy of her own birth-giving body and its process.

Hospital environments can be made to be "home" away from home, not only with changed decor, but with a philosophy that puts women in charge. An excerpt from a letter from a woman, who birthed her child in Pithivers Hospital in France, illustrates a supportive hospital environment where a woman can truly "give" birth.

> I am breathing like a toad: through the top of my throat. Dr. Odent comes in. The waters break. The midwife gently suggests I adopt a semi-squatting position, supported by Eddie. At first I am not too sure, but it does help. As each contraction overwhelms me, I am still moaning very loud, but just for the length of the contraction. Everyone else is calm, quiet, and supportive. Dr. Odent gives me lumps of sugar, for energy, and water (I drink about two pints in all). Suddenly I can feel the head coming down. I am glad because I am looking forward to sleeping, baby or no baby. While standing between contractions, I rock on my feet very gently. The head is visible. Eddie is supporting me. One push and I feel our baby coming out. The midwife catches her; I think she helped turn her slightly. My memory of that second is hazy with excitement. Eddie lowers me and they put the baby in my arms. I am stunned; not a word is spoken. The baby cries a bit and starts looking for the nipple. All is so peaceful and so intense. The midwife and Dr. Odent are in a corner, available, yet making themselves totally unobtrusive. The moment belongs to the three of us. (Odent, 1984, p. 56, 57)

It is the woman who gives birth, with the assistance and support of knowledgeable people. Nothing has been taken away from her own process, and as she births the child she can begin to respond to that child, nourishing the child by offering the breast, and moving toward the responsibility of mothering.

Responsible Relationships

Choosing a Doctor

One of the first things a woman does when she finds herself pregnant is to choose a doctor. This consumer process of "shopping around" for a doctor, and/or midwife who will support a woman's needs, desire, and priorities is now encouraged by childbirth educators and consumer advocates. "The choice of caregiver and a place of birth determine, to a great extent, the kind of birth experience you will have" (Simkin et al., 1984, p. 5). The kind of birth experience is important in self-understanding, and how one takes the responsibility of becoming a mother.

Some doctors, according to Anna, want to take credit for the birth (A1). She and Bill, her husband, felt that their choice of doctor and midwife helped themselves to take their own responsibility for the pregnancy, birth, and the child. Recall Anna's comment about the chance of the death of their child—they would be be seen "as irresponsible, as killers, and murderers" (A1). Pretty strong words. They would be responsible. It was different for Brenda. She said, "Whatever will be, will be" (B2). Everything was left to her doctor's discretion.

Susan was so concerned about the shared medical practice, with the possibility that a doctor she did not know would be present at the birth, that she decided to change doctors. Some of her nurse friends had warned her about doctors who "did episiotomies down to one's kneecaps." But Susan felt unsure of herself. Was it the pregnancy that made her feel so vulnerable? She thought, "How am I going to tell this man?" when she usually felt that one should stand up to the doctor. "I was more paranoid than I was before," and was grateful when the doctor, himself, suggested the referral (S1).

For many years pregnant women have been used to experiencing the effect of the attitude that the obstetrician should take over the guardianship of the woman for twelve months—"supervising food intake, regulation of activities, answering questions, clarifying puzzlements, and advising on handling the baby and generally charting her activities" (quoted in Seiden, 1978, p. 92). Many women are not willing to accept such patronizing anymore but sometimes find it hard to achieve a healthy balance of cooperation with those to whom they go for care.

Take, for example, Christine's discussion with her doctor about the use of the fetal monitor during labour. Christine expressed surprise when she found out that at least one-third of the women in the hospital of her choice had the monitor during labour (C2). In discussing it with her doctor she felt that she had little choice but to accept what he wished to do, although either using or not using the monitor had problems according to the doctor's comments. Her doctor had said:

> The obstetricians, or whoever delivers, have lost their skill in being able to listen to the heart beat, and to know what is going on—because it is so hard to hear externally. The heart beat will go up and down, and race around, and some doctors panic when they hear it just externally and do a section needlessly. The advantage of the monitor is that you can then read the tape, and know. The same problem exists when you don't know how to read the fetal monitor, because you may then panic, (and those are the words he used) and jump in and do a section before you need to. (C4)

After this bit of ambivalence, the doctor said, "But if you don't want to be monitored I won't, but I would prefer it" (C4) Did Christine really have a choice?

"I Don't Want a Daughter"

There was often talk about the sex of the baby. Some of the women played around with the "needle" test, or the "Drano" test. A boy or a girl? It did not really matter. "We would be happy with either" (B2). At the same time as Brenda said this, she also said she would prefer a boy primarily because she expected that her husband would treat a daughter differently than he would a son—like never letting her out of his sight, or questioning her about everything she did. Was she saying that she didn't want her girl to be treated like she was, such as having decisions made for her?

Women realize that in being responsible for a child there is a responsibility to society to raise an acceptable child (Ruddick, 1983). What kind of girl or boy is acceptable to present society? Christine, pregnant with her second child, said that this time:

> Nathan would really like a baby girl. And I kind of think, you know what .. [speaking very quietly], I kind of think I don't know if I want a girl, just because I don't know if I want her

> to face this world as a woman. I still think that men have an easier time . . . I would want my little girl to just go for it, like I think I have—and then I get quite concerned about the kinds of things she is going to have to go through or over—get over—to be a person in this world. I have ambivalent feelings about it. It would be fine but. . . . (C7).

Christine thinks it would be easier to raise a boy, because you could be direct and tell him what the world is like. With a girl there would be more of a dilemma. "My little girl would learn from me—but I'd have to tell her, 'we do *this* here but in the real world *that* will happen'—I wonder if I could prepare my girl child for the world as well as I could my boy child" (C7). Although Brenda did not speak about her concern in terms of woman's position in society, her statement is even stronger in terms of the lived reality of a woman's life. She knows that a girl would be treated differently than a boy and she does not want that for her child. During our final conversation I asked Brenda how she felt about this issue now, she said, "Now Tom says Suzie is going to be a nun, because he remembers how wild he was, and doesn't want his girl to get that kind of treatment" (B5).

Chapter 8

LIVING AS MOTHER: THE TRANSFORMATIVE EXPERIENCE OF LIVING WITH A CHILD ON ONE'S MIND

The Question of Self in "One for Another"

> Ariel: Wherever I am, you're there too, hovering around my shoulders, I'm never alone. Not even when I'm lonely, and quite alone; in my study, or in another city. (Chesler, 1979, p. 190)

Before Brett's birth, Katherine talked self-assuredly about her plans for her birth and her child. She thought out her life carefully, it seemed, like finding work that would support her while she raised a child. She was independent, a woman who did things her own way. She had strong opinions of how she would like to give birth based on research, reading, and talking with others. In fact, it was ten years earlier that Katherine first started thinking about a home birth after reading *Immaculate Deception* by Suzanne Arms (1975). She was delighted to find out there were practicing midwives in her own locality who could make the birth at home a possibility. But in living with Brett, through the Cesarean birth, and the first few weeks, Katherine began to doubt herself. Before the birth she had thought that a Cesarean birth would not necessarily be a problem in the establishment of a good relationship with the baby "because the relationship starts in pregnancy." She said, "It may be that a Cesarean section is a kind of interruption in that relationship, but I think you can establish as good, if not better, relationship with your child afterwards" (K2). Yet she seemed not so sure after, "As I say I've apologized to her I don't know how many times—'I'm sorry kid, that it happened like that'" (K4). She was saddened by the experience, she felt her body had let her down. Katherine elaborated:

> Motherhood is a guilt trip. You feel guilty about a whole bunch of things—you are responsible for so many things and it is impossible to be one hundred percent on top of them all. You think, 'That's what my job is now, you've got to do all those things. It makes me feel guilty. (K4)

The baby crying, not sleeping, being gassy, being hurt by a pin, dressed the wrong way, as well as a Cesarean birth triggered these uncomfortable guilt feelings. "What am I doing that's causing this to be like this? I shouldn't have done—maybe it was the pizza" (K4).

It seems that Katherine is not unusual. Many women experience the same thing. Chicago (1985) noted that although things like a miscarriage, placenta abruptio, or a deformed child, may actually be out of women's control, many women said, "I felt it was somehow my fault" (p. 76). To have a child on one's mind seems to put oneself in question, which can involve change, an inner change, in a woman's understanding of herself. "She [daughter] has forced me to confront dark places in my own soul—my desire to possess, to own; selfishness, or egocentricity; real doubts about the purity of my past loves, past actions (Dowrick & Grundberg, 1980, p. 79).

"Guilt" is the fact of being responsible for wrongdoing. What is it that mothers feel they are doing wrong? It is easy to understand that with the responsibility for "doing," that is caring for the child, that one might feel that the doing is wrong when the child cries, will not sleep, or seems in pain. It is the caring for the vulnerable, the helpless, the dependant, the crying infant that causes mothers to feel the guilt, even if what is happening is not in their immediate control. "That first week was certainly a time of feeling, 'Is this right, is that right, is he alright, am I alright?'(C4). Care of the dependent and needful Other results in the self-questioning that new mothers feel. Katherine said, "I've got Brett on my mind all the time. It's ongoing. It's fragmented my thinking" (K3).

> Ariel is a great teacher. Not only does he force me to *see* my limitations; he has me—kicking and screaming—accepting them. *More:* For the first time in my life, I'm learning about love . . . about what it takes to nourish, maintain human life. (Chesler, 1979, p. 191)

The child is beyond our understanding because the child is beyond us (Smith, 1984). Here is the mystery. The child is our own flesh and blood, yet the Other.

> What has happened? We have lost control of ourselves. Our child issues from a deliberate act, but his [her] presence represents something beyond deliberation. For now there is more to life than what we know, it is mysterious. The child comes as a stranger, but a stranger that we ourselves have created. What makes a child so strange is that he [she] is so familiar. After all we made him [her]. He [she] is our flesh and blood. That is why his [her] otherness is so incomprehensible. The aim to understand the child more completely, to contain him [her], to control him [her] misses the point. (Smith, 1984, p. 292)

The focus turns to the child. Henceforth the woman's attention is divided.

The Giving Body

Nourishment

"I guess I started to feel motherly when she responded to something I did—if I talked to her, she seemed to quiet—seemed to know I was there and able to comfort her" (K3). Jane felt it was through the daily tasks of feeding and caring for the child. When my own child was about five months old I took him to the Health Clinic for immunization and a check-up. He was a healthy child, chubby and active. As the nurse weighed him and realized that he was still being nursed, without the introduction of many other foods, she said to me, "Well, you are quite a cow, aren't you!" I was furious! I didn't know that my anger was a reaction to the importance for me of my nourishing and life-giving abilities. In using the metaphor of a cow, the nurse probably did not know that the "Goddess as cow, ruling over the food-giving herd," is one of the earliest historical objects of worship (Neumann, 1955, p. 123; Corea, 1985, pp. 60-61). The nourishing ability of women is something to be cherished. It is important to the child, and to the mother—it ties mother to her child in necessary ways.

> To nourish and protect, to keep warm and hold fast—these are the functions in which the elementary character of the feminine operates in relation to the child, and here again this relation is the basis of the woman's own transformation. . . . After childbirth the woman's third blood mystery occurs: the transformation of blood into milk. (Neumann, 1955, p. 32)

The symbols that belong to the vessel character of the belly during pregnancy are enclosed forms (such as jar, kettle, or oven), whereas the symbols that belong to the vessel character of the breast are open in character (bowl, goblet, cup, and the Grail). These symbols accentuate the giving, protecting, warming aspect of the Feminine archetype of nourishment (Neumann, 1955, p. 46-47).

> Body-vessel and mother-child situation—the positive elementary character of the Feminine—spring from the most intimate personal experience, from an experience that is eternally human . . . it preserves its closeness to the central personal phenomenon of feminine life. (Neumann, p. 147)

How then does this nourishing aspect of the mother-child bond transform the woman? Is it this aspect that connects women to children in such a way that from thereafter the "child is always on one's mind?"

Katherine talked about how she is rushed home from shopping with thoughts of the child. "I felt it (in my breasts) if I was even just thinking about her. I would start to feel really full and kind of anxious to get home. I'd sometimes just forego doing something that I thought I would do, just to get home" (K4). Jane, too, remarked on the time it takes to really see the child as an independent person. "I left Lisa with Jim and I phoned when I got there fifteen minutes later and then rushed home. The ties are incredible. The umbilical cord is not really cut for the first while. Now I can go out and not worry about her as much—I don't need her in my sight so much" (J4). While the primary interest of mothers, early on, is the preservation and nourishment of this new life, it is not long before other interests, such as fostering the child's growth, and shaping an acceptable child also become important (Ruddick, 1983, pp. 219-223). These interests demand change on the part of the woman which involves moving away from the child.

Attentive Love

There is danger in romanticizing mother love. Romanticizing negates it, puts it down, makes it something private, which may not be valued in the public world. From "a child only a mother could love," to the once a year accolades of Mother's Day, the love of the mother gets taken for granted. In its taken-for-granted-ness it becomes "naturally" a woman's duty and domain (Ehrensaft, in Trebilcot, 1983). What is this special love, this love that mothers feel? How does it come about? How does this love affect the woman herself, and her understanding of herself as mother?

> The love of children is not only the most intense of attachments, but it is also a detachment, a giving up, a letting grow. To love a child without seizing or using it, to see the child's reality with the patient, loving eye of attention—such loving and attending might well describe the separation of mother and child from the mother's point of view. (Ruddick, 1983, p. 224)

Weaning, according to the dictionary, means the substitution of other than mother's milk for nourishment, but one wonders if weaning starts as one lets the child go in daily ways. It is being comfortable with someone else holding and soothing your baby, letting someone look after the child while you go out to dinner, or feeling comfortable with the child staying overnight with grandparents. Jane's admittance that she does not need Lisa in her sight so much may be an aspect of weaning—or when Anna responds to people who remark on Jena's beauty by saying, "Yes, she is, isn't she?," rather than, "Thank you." "After all," said Anna, "Jena is her own person, and should get the credit for being beautiful" (A6).

Christine talked of valuing David's own needs and working around his sleep patterns or eating patterns, or even just allowing him to be fussy if that is what he needed to do.

> When he cries, he gets terribly upset and that is hard, it is hard for me to hold him when he is doing that. I try to just hold and comfort him. . . . You just have to let him cry—as long as he is not choking or in danger—I just try to be here and let it happen. It is not easy. (C4)

In a legend of the Grail it is said that a king, paralyzed by a painful injury, offered the Grail to the first person who asked him, as the guardian of the Grail, "What are you going through?" The love of Other is that kind of love (Weil, as quoted in Ruddick, 1983, p. 224), an attention and respect to what the child is "going through." This nurturing, thoughtful love is expressed by letting Jena feed on demand, and acknowledging the child's own patterns of sleep. Within this love Anna is respecting the individuality of her child, and the child's separateness from herself as the mother.

Yet in the weaning from the breast, and the recognition of the separateness of the child, there is still the realization that the mother's body, and her attentive love, hold an ongoing and lasting aspect of support for the child. Twelve years old, still a child and yet rapidly moving into the possibility of manhood, my son asked if he could sit in my lap. As his growing body covered my lap and my vision, he wondered how he was as a child in my lap. We laughed and tried different positions to capture again what it was like. He said "You know, this is my home!"[1] A mother's body gives the child the sense of home. The very fact that the woman's body carried and nourished the child ties a mother to her sons and daughters in a unique and intimate way. It does not mean, however, that women are alone in their giving of attentive love. It may be "naturally" theirs—but it may not be "only" theirs.

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[1] Neumann (1955) talks about this "loss of the original home." Birth is not only a release into life but is also experienced as a rejection from the uterine paradise.

Relationship to the Child

Attachment

The women talked of their first encounter with their child. Anna said: "Later on in the day she was born, I came in here and put some music on—and just kind of stared at her and was totally overcome with emotion. It was just looking at her and hardly believing that she's really ours" (A4). Katherine could not see Brett just after birth as she was just too tired and sleepy from the drugs, but the next morning she could not wait for the nurse to leave so that she could have a good look at her daughter. Brett was different than Katherine expected. Her dark hair, her face, her chubby cheeks were a big surprise. At this point Katherine was just curious, looking at her baby like an object to examine and see all of her. Susan, on the other hand, was not surprised by her baby's looks, "He came out looking how I had expected. I wasn't surprised" (S4). Earlier in pregnancy Susan had maintained that she had always thought her baby to be a separate person, so she was not surprised but just felt good about feeling him and seeing him. Jane's remarks, too, show her beginning relationship with Lisa as a separate being. "She opened her eyes and wasn't crying, and had a very good long look at both Jim and I, very intelligently, almost as if she recognized us by our voices or something. It's just so overwhelming . . . that you can't turn her down" (J3). Often women want to see the baby's face, to have face to face contact, to really see the child as a separate being, to look into the child's eyes. Eye contact with the infant may be a critical release during the first first hours (Seiden, 1978, p. 85). The mother's response to the child is very much dependent on the infant's response to the mother.

It is through the separateness, the separation of the being that stands some distant from us, that confirms us. It is through the Otherness of the baby, and seeing that Otherness, that the woman begins to understand herself in relation to that person. "Little ancestor, sweet baby, how you temper me, deepen. Like an ancient smithy working slowly" (Chesler, 1979, p. 281). One-for-the-Other starts with the cutting of the cord.

> So after he showed her to us he handed me the scissors and wanted me to cut the cord. I didn't want to. I wanted Jim to do it, but the doctor insisted I should cut it. Finally I did it but, boy, it was tough to cut, like a thick rope. (J3)

It is difficult cutting the cord—that irreparable cut—that accepts her infant as Other. For mothers it means changing with the needs of the child. The physical body processes of pregnancy and birth, as well as nursing, require the mother to accept constantly shifting definitions of herself. From being one, to being two. When one looks at and sees the child there is no choice. "You can't turn her down."

When we think of Brenda's experience, when she turned away from her baby at birth—refusing to hold her and refusing to look at her—one wonders how her move to motherhood was made more difficult. Brenda recognized that she was holding back from looking at her child. She said, "I figured that she would be messy—red guck all over her, or some kind of discharge that would come down the birth canal with her. I didn't want to see a kid that was all yucky" (B3). Did her resistance to look at her child retard her transformation to mother? Did her reluctance to accept the "guck" as well as her daughter's beauty make her progress to mothering more difficult? The objectifying of women's bodies is common in this society—and it is experienced by women as well as men. Brenda's response to her body in pregnancy, as ugly, and her distaste of the vernix and blood that may be present on her baby, may distance her from the bodily bond. Breastfeeding was also abhorrent to Brenda. "Thank goodness for formula," she said (B2). Does this bodily estrangement deny her a natural bridge to attentive love? For her there was no wonder-ment of the process of pregnancy and birth, no awe or emotion in the mystery of birth. For Brenda, the pregnancy and birth were "gotten through." "Some women really enjoy being pregnant, but I'm not one of those. It is beautiful to have a baby, but I'd be glad it were over in two months" (A4).

Separation

My son was perhaps four weeks old—it is really hard to remember—although you once thought you would never forget. I was nursing him every three or four hours. I was tired, and had lain down for a nap. After a long sleep, I woke refreshed. Suddenly thoughts of my child rushed through my body—my breasts were painful and were starting to leak. But why had I not heard his cry? I was confused by this long sleep. I did not expect that I could have slept through his need for me. I found him in the garden contentedly sleeping in his carriage beside his father. His father had changed him and fed him with the breast milk that I had saved. Someone else could feed my baby! I was not always needed! My husband remembers this day, too. He found out that he could care for his child in a new way. Before that experience his care had been for us as a mother/child, as one. Now he had a glimpse of his unique and personal relationship with his child. He had fed him. It was a turning point for both of us. A weaning from the mother and a bonding to the father. "Naturally" women nurture babies, "culturally" others can also be a part of this important task. This example shows a kind of dialectic of attachment and separation (R. Burch, Personal Communication, May 17, 1986). First, the intrauterine bond and the separation of birth, for the sake of the I-Thou bond of mother and child, and, secondly, the separation of growing-maturing mother and child for the sake of a deeper I-Thou bond. Yet, both forms of separation are not simply something the mother/parents grant, the baby is born in its own time. The child gradually realizes adult freedom because the child wins it.

Christine, who from early pregnancy talked about her need to continue in her career, felt that she could be a good mother and still pursue her career. She said:

> There is quite a bit of challenge in combining the two. It is sobering thinking about the future, in maintaining my career and my relationship to my husband and child. And yet what I couldn't anticipate before was how important my child is to me and how strong that part of me is. (C6)

In fact, her mothering influences her work, and she thinks that is good. "I can't switch off who I am with my child. He is too much a part of me. How I relate to my husband and my child is where I get my ideas" (C6). Of course, is not always easy for Christine, since both she and her husband want to be parents and have careers. Sometimes she thought, "Better if I were a happy housewife," at the same time as knowing "that would be a disaster" (C7).

Katherine, in moving back to full-time work, said to her boss, "I have too much to do" (K5). She would never have said that before. Before Brett she would have come early or stayed late to get the work done. Now she is not prepared to do that. Her thoughts are directed to her child. She cannot ignore her relationship to her child. The reality of a mother's attachment to her child and her work reinforces the chauvinistic prejudice about the reliability of women workers who are mothers. Instead of accepting that reality as negative, the work world may benefit by attention to "having children on one's mind." As more fathers take on the daily responsibilities of children, these negative attitudes may change.

For Anna, the first few weeks at work were the most difficult. She took a photograph to work with her which showed Jena pouting. It was just how Anna, herself, was feeling. The decision to go back to part-time work was not easy but she knew that she too needed the stimulation of being "in the world." She did not want, as she said earlier, "for Bill to be her window to the world" (A2). She needed to have her own place. Brenda worried about being bored at home and went back to work about two months after Suzie was born. Susan talked about her need for adult companionship. Jane and Susan had difficulty thinking of someone looking after their child, as all the women did to some extent. But for Jane, her decision to be the primary parent in the ongoing care of Lisa, was based on two factors. First, that her husband is "really very happy in the role of provider," and secondly, she felt that she could go back to her career when Lisa is older, "but I can never go back to the time when she's young and dependant" (J5).

Home for the Child

In accepting responsibility for the world, now the world of children, it is necessary to reassess the notion that the woman as mother must be the prime caretaker of children and all that is involved in that role (Dinnerstein, 1976; Chodorow, 1978). Anna, Christine, and Susan talked, rather casually, about their husbands staying home to look after the child. Christine, said that it was a possibility but she wondered what she would miss if he should do that (C1). Although Bill really liked the idea of staying home, Anna thought he was "romanticizing" it, especially when he realized how demanding Jena was to look after (A6). Susan thought that she would do better at home than Paul would. "I think that he would go nuts, he has to be doing things all the time—I don't think he would be happy at home. I do a lot more homey things. I sew and do crafts. I can teach the piano. But I wonder if I will be able to stay home without much adult contact" (S1). So, while there is ambivalence, it is usually women who stay with the child, or make the arrangements about who will look after the child. Christine, Brenda, Katherine, and Anna searched out the neighbor, sister-in-law, mother, or the stranger who would care for their children while they returned to work. Finding the right person was a problem for all of them except Brenda. Brenda had decided before the birth of Suzie that she would go back to work, and had found a neighbor to care for her child. Because of her shift and weekend work, it was often Tom, her husband, who would baby-sit Tom's use of the word "baby-sit" indicates his relationship to the job of caring for his child—a word often used by fathers, rarely by mothers.

The children had taken some time to adjust to the arrangement of childcare but each mother thought that the child had benefitted in some way from it—being with other children or learning different ways of doing things. Each woman felt that the time spent away from the child made her more able to give to the child when she was home.

Christine spoke at length about her childcare arrangements because although her time was flexible at graduate school she had considerable pressures that had to be met. One of her advisors had accused her of "putting her child at risk" which, she said, if she had not been so sure of herself, would have brought her to tears. She felt that he, as a male, did not understand her need to do what she was doing, and, of course, would not question a new father in the same position (C7).

Yet, the problem of child care is a real one in today's society. Some feel that there should be more and better daycare, even universal daycare. Others feel that no daycare can solve the problem of the child's need for a home and the freedom from institutional restraints that the home possesses. What is important about a home? A home is a place where one can be oneself, where one is accepted for oneself. It is also the place where there is a mother, a father, grandparents, or other people who are devoted to the child in an "irrational" way, made possible by unconditional love. While there are no perfect parents, is no perfect home, the place which a child can gain the basic foundation of human life may best be found in the home within the fold of loving parents.

Minding the Time

"Days are full of doing things," said Jane, "but nothing gets done" (J5). The world of a woman as mother gets turned upside down in unpredictable ways. Chicago's (1985) image of the faceless lady expressed the price women pay as nurturers—"as trapped by the needs of those one gives life to" (pp. 92, 96). Chronic fatigue, disorganization, multitudinous commitments, guilt, a fragmented existence comes with the nourishing requirements of the Other, the child. It was what

Christine was worried about, "You see, work is manageable, you know what you can do, you organize" (C1). She saw women in her work who appeared fatigued and harassed who claimed they had trouble trying to accomplish all they needed to do. How does one organize the time with a new baby as responsibility?

> They say to be there at eight, so you try to be there by that time, which may not necessarily fit in with the way she would normally be doing things. (K4)

> I think I am still organized to a degree, and I think about things ahead of time. When I start making dinner, it's two in the afternoon, when he's settled down because I know that at supper time he is up. I just take advantage of the time I have. (S5)

> If you want to have sex, we have to do it now because it is twenty to ten and the baby is asleep. "Whatever happened to spontaneous lovemaking?" (C4)

Living with a child changes one's relationship to time. Instead of hours and minutes, work time, coffee time, or dinner time, etc., the days are broken into sleep time, feeding time, bathing time, and laundry time. It may seem endless and one wonders if one can live through it. There is never enough time for sleep. There is not much time for oneself, as mother.

How can we give enough time to children? We hear about full-time mothers, part-time mothers, latch key children, and even the notion of quality versus quantity time. Valerie Polakow Suransky (1982) in her book *The Erosion of Childhood* looked at the institutions that are set up to care for children. Here we see slotted time for children: going to the bathroom time, eating lunch time, cleaning up time, and so on. Where is the freedom of play time, doing nothing time, and private time, that we all, especially children, need?

Space for the Child

> Giving birth changes how you see the world. You know, when I walk down the street I see each person being born. I exist in relation to human vulnerability and nakedness as never before. (Chesler, 1979, 191)

"I Know how Babies are Now"

Both Susan and Anna remarked on how they see the world, especially other children, differently now. "It is hard to see parents who are mean to children, or even think of the fact that some mothers put their child on a four hour schedule" (S6). "When I see a child on television, it is like seeing my child. I see all children as my child," said Anna (A6). She talked of the earthquake in Mexico where babies were found in the rubble days later. It is the knowing—"what babies are like now," and imagining them crying and crying, all alone—that moved her. She does not think she would have responded with such emotion before Jena's birth—and she thinks it has added a dimension to her life that she sees as good.

Yet Anna wants a happy balance between emotion and reason. Although she is happy for her new "softness," as she calls it, being touched by small animals, being more cuddly, with more need for closeness, she wants to be part of the larger reasoning world as well. Katherine, too, said, "I had to make myself watch the news so that I would know what is going on in the world" (K5). In the recognition that the:

> Passions of maternity are so sudden, intense, and confusing . . . we often remain ignorant of the perspective, the thought, that is developed from mothering. . . . Intellectual activities are distinguishable but not separable from disciplines of feeling. There is a unity of reflection, judgment, and emotion. This unity I call "maternal thinking" (Ruddick, p. 213, 214).

The "child on my mind," then is a way of being, and not merely an emotional reaction to children. It is a way of being and thinking about and experiencing the world—the world as a good place for children. Anna, earlier in pregnancy, wondered if this is true—if the world *is* a good place for children. She said:

> I get so frustrated with people who tell us all the horror stories about children. We were out for dinner and all they could talk about was how bratty kids were. I thought, "Why bother, why have kids?" "Don't tell me this stuff, I don't care to hear it." I think a lot of times that this world doesn't cater to children. There is a certain amount of prejudice against children. I know you have to change your life, but [one must] change it to the benefit of both. (A3)

In a society that does not value children, as children, it may be easy to put one's child out of one's mind. In a society that esteems public work, that continually strives for better material goods, that discounts child care, it may be easy for the woman once "fragmented by the child on her mind" to accept society's dominant goals, in her search for self worth. Germaine Greer (1984) points out that within our society the world of the "adult" and the world of the "child" are becoming more distant and unequal. But the child needs a mother. Who will mother the child?

"I Know how Mothers are Now"

The mother needs the child. In her recent book *The Anatomy of Freedom* (1984, pp. 192, 196), Morgan writes about the Non-Governmental Organization Forum, (semi-officially under United Nations aegis), which took place in Copenhagen in 1980. Here "ordinary folks" from local women's organizations, feminist alternative media, and women's religious, health and community groups came together to talk. Here an Iraqi refugee told an American Jewish feminist that her eleven-year old son has just been sentenced to five years at hard labour by the Saddam Hussein regime. "My God, my son is just that age," replied the American woman. They weep in each others arms. Mothers know how mothers are—how mothers need their children. They weep in recognition of the pain of seeing a world that has lost sight of the child as child. Living side by side children prompts increasingly reflective questions—we begin to doubt ourselves and feel guilty. Did I do right? Am I doing right? As we are transformed to mother we are forced to question ourselves.

Chapter 9

ONE MOMENT IN THE TRANSFORMATION OF WOMAN TO MOTHER: THE MOMENT OF BIRTH

Introduction

In chapters three through eight, I have explored the transformative moments (themes) that women experience as they become mothers. These moments—the decision to have a child, the experienced presence of the child (I-Thou relationship), the separation of that experienced presence which can lead to integration and wholeness, the appropriation of responsibility for oneself and the world as one accepts the presence of the child, and the "mind-fulness" to the child that occurs with a child in one's life—are not stages or steps in a process. The notion of "moments" encompasses an enlarged view of experience, unifying the two words "momentous" and "momentary" (O'Brien, 1981, p. 47). The moments of transformation, as hermeneutically revealed, may even be seen as a hologram where the "part is as great as the sum—the part *is*, in fact, the sum" (Morgan, 1984, p. 148). That is, the moment "of the decision to bring a child into one's life", in itself, shows the transformative experience. And yet the transformative moments interact with and intensify each other. For example, within the moments of decision comes responsibility. Or as a woman experiences the presence of the child, the moments of decision are renewed. Or as the presence of the child is experienced in different ways, the separation becomes possible, and, indeed necessary, and through separation comes the overwhelming experience of having a child on one's mind. Thus transformative moments, through hermeneutic encounter, do not fragment the wholeness of the childbirth experience, but reveal the depth, the profoundness, the complexity, and the perplexity, that "becoming a mother" offers women.

There is, however, one moment, within these transformative moments of becoming mother, that gets special attention. It is *that* moment, *the* moment, the *moment of birth*. This moment of birth, this interval, will be the integrative focus of this chapter, relating the various concepts and themes discussed in this study to each other.

Elsa's Birth[1]

Elsa was born under the full moon
on the first of Spring.
Everyone in the room bore her forth.
My job was in a way the easiest
albeit the most terrifying.
I had to look the Birthforce in the eye
and get out of the way
while it drove through my body
like thunder through tissue paper
demanding that I open up
although with every additional opening
it grew more relentless. . . .

The pain did not lodge in my body
but went out each time, with the note.
There was no wasted energy. . . .

Some time near the end
I pushed
and pushed until I thought my body would break.
The head was out
I heard voices telling me so
but the vibration in the room was mounting strangely
and I could only concentrate harder then ever to meet it.
Finally: expulsion
On hands and knees I felt myself empty.
The relief was stunning. . . .

The room was abuzz with white fear now
but I was not afraid
for Death was in the room,
and in this presence
being afraid would be just plain silly. . . .

So I just looked at the creature in the midwife's arms, no
"positive thoughts," nor "prayers,"
just pouring out my soul to that creature
And she gurgled . . . she caught her breath . . . she lived,
soon radiating strength, energy from the love directed
towards her from us and from the universe
that brought her here. I always believed in miracles
but I never thought I'd ever open the door to one.
Everyone who witnessed that door opening was transformed,
because the prize for looking Death in the eye
is Rebirth.
(Murray, 1983, in McMahon, Cohen, Kaiser-Cook, & Fischer, Eds., p.34)

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[1] I am grateful to Penny Simkin for bringing this poem to my attention.

These excerpts are from one anecdotal image of *the moment of birth*. Strongly felt in Elsa's birth—in all births that I have been a part of—is the tension, the excitement, the fear—"the holding one's breath." We may not call it the "Birthforce" but we know what it is when we feel it. It is tied to the wonder of birth and death. It is tied to the mystery of human life. It is felt in the questions, "Will the baby be all right?" "Is the baby okay?" It is the momentary stillness—the attentiveness to the first sound, the first breath, or the first cry. In this anecdote, too, other factors can be seen. The birth takes place in some time, some minutes, or some hours. The woman's body has a rhythm of its own, contractions come and go, become stronger and longer, and in a sense, take over. There is a community of people who support the strength and capability of the woman, and who greet the child with love.

Such a birth could have taken place anywhere, in a home, or in a hospital, yet in this account the impact of obstetrical, technological knowledge is not strongly felt. But, as obstetrical knowledge is the foundation of birthing practice, perhaps this mother's account is just a dream. Does the real picture of birth look more like Atwood's (1985) description?

> A pregnant woman wired up to a machine, electrodes coming out of her every which way so that she looked like a broken robot, an intravenous drip feeding into her arm. Some man with a searchlight looking up between her legs, where she had been shaved, a mere beardless girl, a trayful of bright sterilized knives, everyone with masks on. A co-operative patient. Once they drugged women, induced labour, cut them open, sewed them up." (p. 124)

However, this portrayal, too, may be a caricature.

Approaches to Knowledge in the Moment of Birth

The forms of knowledge explored in chapter one (the obstetrical view, the midwifery view, the methodological and the critical view) will now be brought to the moment of birth in order to particularize the meaning of the experience of transformation. Taking a critical stance, I will raise questions about the differing approaches to childbirth knowledge that come into play during the minutes or hours surrounding the birth. This will be done by citing concrete examples (many related to the fetal monitor as it is routinely used as part of many women's experience of birth.) The fetal monitor is a realistic example of obstetrical practice. Midwifery and methodological practices will also be addressed. Again the lived reality of time, space, body, and relationships will structure the discussion: preparation for the birth (lived-time), the contractions of the women (lived-body), the tension or excitement of awaiting the first breath (lived-space), and the welcoming of the baby (lived-relationships).

Preparation for the Birth

Eventually the moment of birth arrives. Women come to it with various kinds of preparation. Some women attend childbirth classes, some have regular contact with the doctor or midwife, and some read and study on their own. Of course, too, there are some women who do not actively prepare in any of these ways. The moment of birth is affected by the preparation. That is, the moment of birth depends on how women understand themselves as childbearing women which is bound to the varying approaches of childbirth knowledge.

One study (Mills, Paddon, Edwards & Kelpin, 1982) found that expectant parents, who attended childbirth classes taught by a community health agency, were most interested in gaining information about the usual process of labour and delivery, breathing and relaxation techniques, ways fathers can help and support, recognizing warning signs, nutrition, and ways mothers can help themselves. In these classes (as well as in classes taught within hospitals, private classes, and childbirth education associations) relaxation techniques, breathing patterns, changes in positions, and massage are often included in order to help the women gain a sense of their own participation in labour and their ability to handle the contractions. Included in the classes may be explanations of the procedures that women may encounter during the moment of birth (the two to twelve hours or more), such as intravenous administration of fluids, medication, rupture of the membranes, as well as the use of the fetal monitor.[2]

A problem arises when one knowledge approach is used in preparation for the moment of birth which occurs in an environment dominated by another view. Such a situation occurs with different methods of breathing patterns (both methodological such as Lamaze or Bradley), or more problematic, when one (methodological) approach is used to prepare women for an environment where another (obstetrical) approach is practiced. In such an environment, the one may be felt to get in the way of the other. Take an example where methodological approaches clash with obstetrical practice. When the internal fetal monitor is attached to the baby's scalp by the artificial rupture of the membranes (amniotomy) the strength and quality of contractions will increase and the labour may be shortened. Because of this sudden acceleration in intensity of contractions, women may no longer be able to handle their own relaxation, and breathing pattern, which may lead to breakdown of self-confidence, technique, and possibly, to further intervention such as medication or forceps.

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[2] Starkman (1977), Shields (1978), Molfese, Sunshine, & Bennett (1982) have investigated women's experiences with and reaction to the use of the fetal monitor during their labour. These studies began from a position that the monitor will be used in labour and recommended the need for appropriate information so that women understand its use and accept its application.

Another example: Methodological and midwifery approaches accept labour and birth as a normal physiological process within the life of a woman and her family. With such a view, the woman will follow her own process, using what she has learned to "go with" and handle her own contractions. As this woman enters a place of birth where the staff takes charge and directs (tied more to obstetrical practice) the woman may feel that she has lost a sense of her own control and is not able to handle the moment of birth as well as she could. Think of Katherine, who prepared to have a home birth with the help of midwives, but needed to be transferred to hospital where her baby was eventually delivered by Cesarean section. The move to the hospital was a turning point, she said, as the forms of knowledge used in each situation were markedly different (K4). In hospital, Mike, Katherine's partner, felt that he "was removed from the situation of the birth," and "things really were out of their own hands." If midwifery knowledge had been practiced in the hospital environment (with the support of obstetrical knowledge) Katherine and Mike may not have felt the change so acutely.

In childbirth classes to prepare women for home birth using midwifery knowledge, the conflict between preparation and practice is not present. For example, women who plan for a home birth know that there will not be medication to help them with their pain—so the question of medication is not considered in the moment of birth. In hospital, those same women (not wishing to use medication), knowing that medication is available and offered, may accept and even desire it when involved in the intensity of the pain.[3] It is not a question of the use of medication, but a question of how women's acceptance of medication is influenced by the knowledge approach used in different birth environments. It is possible that the same women would have a different birth experience depending on the application of knowledge at the time of birth (eg. use of medication or not). Congruency between knowledge forms used in preparation and in practice at the moment of birth influences the experience of that moment. So while childbirth educators try to prepare women for the moment of birth with a particular approach, that preparation becomes problematic when another approach to childbirth knowledge is used in the actual birth.

One solution for reducing this conflict would be for each hospital to have its own classes teaching the form of knowledge that is used, and for home birth participants to have classes given by the midwives. This practice is occurring to some extent. But there is a inherent problem here, too, in that a dominating form of knowledge, such as obstetrical knowledge, may take over childbirth practice completely.[4] At the present time childbirth classes, especially those offered outside of hospital or home birth practices, do provide women with information about differing approaches to childbirth practice. While the problem of incongruency between education and practice remains, these classes do achieve an advocacy role as women are presented with options.

Another solution would be for midwifery knowledge (birth as a normal process for women) to become the foundation of childbirth practice with obstetrical knowledge used when necessary medical intervention is required. Methodological approaches may still offer different tools but the potential conflict in practice at the time of birth may be reduced. Such a philosophy would put the obstetrical and methodological knowledge in the service of midwifery knowledge, not replacing, but supporting the basic premise that childbirth is a normal process for women.

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[3] According to Melzack et al. (1981, pp. 361-363), 81% of "trained" women requested epidural block for intense pain even though they had been advised against it in their childbirth classes.

[4] In some ways this, too, is happening already, as was seen in Christine's discussion with her doctor about whether or not to accept the use of the fetal monitor (Chapter 7). If the obstetricians have lost their ability to listen to the fetal heart beat in clinical ways, and depend on the fetal monitor, the only way to check a diagnosis of fetal distress is to use another technology, analysis of a blood sample obtained from the baby's scalp. One technology leads to another.

In chapter seven the transformative moment of responsibility was explored which revealed another aspect of preparation for the moment of birth. Women who prepare for the moment of birth at home have to prepare the environment—with sterilized towels and sheets, pads, and other necessary supplies needed for the birth. Women who prepare for the moment of birth in the hospital need to pack their bag—decide what supplies they will need for their themselves—as the supplies needed for the birth are provided. Here we see, again, the view of midwifery knowledge that childbirth is a normal, although special, event of everyday life—obstetrical knowledge sees birth outside the normal—within the framework of high or low risk. Women themselves prepare for the birth in one situation whereas the experts prepare for the birth in the other. Preparing to take responsibility impacts the moment of birth. Of course, not all homes are appropriate birth environments and not all women would be able to provide the necessary supplies for birth. Yet the questions of how women prepare for the moment of birth and how they prepare to take the responsibility that becoming a mother entails, are important ones.

The Rhythm of the Contractions

The rhythm of contractions takes central focus in the moment of birth. I recall them vividly. I remember the beginning—thinking "Oh, here we go again," and the ending—the big breath, the momentary reprieve. As the contractions became more powerful—they took on a life of their own—there was nothing to do but let them pass. There is a different sense of how contractions are seen in each knowledge approach. I was "in" the contraction, moving toward the birth of my child. The methodological approach gave me tools to handle or apply to the process, the contractions were to be controlled. Obstetrical knowledge stands outside to record the process. In chapter five and six, two moments of women's transformative experience—the presence of the child and the value of the labour of "giving birth" were discussed. Keeping in mind these moments of women's transformative experience further consideration of the impact of the fetal monitor (obstetrical knowledge) will be explored.

In one sense it would seem that the fetal monitor could support the intertwining presence of the baby within the life of the women, as the heart beat of the baby and the contractions of the women are, together, so vividly displayed and recorded. One might expect this information could assist women to be "in" the contraction. In another sense the mother/baby unity is disrupted by the recording—as each stands alone, for everyone to see. The contractions, now, can be "felt," or "viewed" by others in the room—by the staff and the woman's partner. This visual understanding of the contraction changes the experience of the contraction for the woman. She no longer has to say to herself and others, "here we go again" but can be told by others that she is having a contraction (M). While "it is interesting to watch," said Katherine, "if you start watching it you are not necessarily in touch with what you are feeling" (K3). In losing a sense of what one is feeling it is easier to be directed by others, as Melissa pointed out,"They, the doctor and my husband, could really coach because they could see when the contractions were coming without having to ask a lot of questions of me, or wonder where I was at" (M).

Other women felt that the monitor helped the husband or partner to feel more involved in the labour. The husband/partner may now even seem to know more about the contraction than the woman herself. Christine said, "He felt more involved because he could say [to me], 'That was a strong one' and that would encourage me because I made it through it. He could feed that information to me" (C3). At the same time, though, Christine described very clearly what her own contractions were like. Len also described the monitor as invaluable in giving him information about Natasha's contractions. Len said he would have felt helpless if he did not have the monitor to tell when the contractions were starting so he could give directions to Natasha (N). However, Natasha said later, "I wanted to do it on my own and I felt capable, but I don't think that you are altogether there. I was relying more on what Len thought than on what I thought" (N).

With midwifery knowledge used at her home birth, Anna did not use the fetal monitor. Bill talked about how he worked with Anna, breathing with her with each contraction and stroking her body as she relaxed between the contractions. He said, "I felt so much a part of it." It is possible that the partner's help and involvement is equally or more desirable if he can observe her with his hand on her abdomen, focussing and sharing his attention with her to attune each other to the rhythm and nature of her labour as she was feeling it. While on the surface it may seem that the monitor promotes the working together of the partners through labour, it may, in actuality, incline women to depend more and more on others to give information about themselves. They come to rely less on what they themselves think and experience, which may lead them to be robbed of their self-confidence and the feeling that they could manage for themselves (Dunn, 1978, p..298).

Towards the end of Christine's labour, when the internal monitor was in place, Christine was having difficulty knowing if and when she was having contractions at all and needed to be told. She said, "I literally could not tell you if this was just my muscles aching from pushing or if this was a contraction. And I said to Nathan, 'You will have to tell me. I cannot feel when it starts'" (C3). Not only had Christine lost touch with her own body sensations she heard the baby in the machine beside her. "That is where it was, over there! That was where his heart was, there! I could hear it all the time" (C3). Then she said, "I felt tight, closed, terribly tight. I felt tight and that nothing was coming to the bottom, nothing was coming to where it should be." And later, "The doctor was getting ready for delivery because I remember him coming out in various stages of green. He was getting more green each time he came in [laughs]." Christine had lost a sense of her own contractions, heard and experienced her baby outside herself, and could only tell that she was getting ready for delivery because the doctor was getting dressed in the appropriate clothes.

Some women felt the information displayed on the monitor was all the information that was needed in their care. One woman felt that the nurse wanted her just to go to bed, with the monitor on, because other information, such as how the contractions were being experienced by the woman, was not as important, or indeed essential. Another woman said that her obstetrician would "know everything that was happening to me just by watching the machine" (Starkman, 1977, p. 501).

The bodily experience of contractions in the moment of birth is changed by the fetal monitor and this change may affect the way women come to understand their own experience. On the one hand, Victoria, within the application of midwifery knowledge, could say, "It was an incredible experience—I wouldn't have thought I could be so in touch with my body." On the other hand, Christine, within the fold of obstetrical practice, was attached to a fetal monitor which displayed the uterine activity with such clarity, making it possible for these readings to become the primary focus of everyone, even Christine. Such a situation may have led Christine to lose a sense of her rhythmic contractions and her own inner experience of moving her baby out of her body.

With the use of a monitor that could give information that in some ways is more accurate than the woman could give herself, a scenario can be envisioned where a woman need not speak at all. In fact she would have nothing to say because there would no longer be any words to describe her sensation of painful contractions. In such a situation others could direct and control her labour, telling her when her contractions are starting and finishing. She would not experience her baby inside but rather as a separate being who is delivered through the coordinated efforts of others. She would just be the vehicle of the child's passage into the world where he or she will be kept warm, measured, and tested. It would be hard to tell the difference between the woman and the machine because they would all act machine-like with wires and electrodes attaching themselves together. In order to avoid such an extreme caricature, consideration must be given to how women come to communicate with doctors and nurses, what language is used; how husbands and friends support women in their birthing process; how women are separated from their babies, even before birth; how machines almost seem like humans; and more importantly, how humans come to act like machines. These kinds of concerns place in the foreground the question of how to live as humans.

Listening for the Baby

Is the baby okay? This question, that stands strong in the tension surrounding the moment of birth, is also experienced differently in various knowledge practices. With obstetrical knowledge and the use of the fetal monitor, this question is partly answered—even before the birth itself. This is powerful and dramatic. While tools have been used in childbirth for years with auscultation of the fetal heart reported as early as 1816, it is only within the last two or three decades, that it has been possible for the listener to the baby's heart beat to move away from the labouring woman. So from the "ear on the belly," the listener (the doctor, nurse, or midwife) has moved to the end of the stethoscope, to the other side of the room, to another room, and, now, even to another town! According to Tucker (1978, pp. 116-118), displays are being developed so that professionals can view a number of patients simultaneously. Alarm systems, including a computer printout, identify the problem; for example, "Room 3, severe variable deceleration;" and telephone transmission of the fetal monitoring data can be sent from a small rural hospital to a major perinatal centre for expert assessment. Thus, the fetal monitor becomes an important tool in listening to the baby and answering the question of the baby's health. Of course within the midwifery approach the fetal heart rate is also checked—usually now through the use of an ultrasound Doppler. It, too, is dramatic. The difference for Katherine, who experienced both, was that the Doppler was hand held—the midwife was present—instead of just a machine (K3).

Christine felt that the fetal heart monitor was reassuring. She said, "I didn't think much about the baby and the reason I didn't was because I could hear his heart beat. I could hear his heart thumping all the time and it was fine" (C3). The baby's vital function, the heart beat, is heard in the machine. Every one (mother, father, doctor, and others) can now hear and see, on a graph, the baby's heart beat. So while dramatic, and reassuring of the baby's liveliness, the machine as an extension of the baby changes the focus of everyone, even the mother. The doctor, the father, other staff, and even "mechanics" hover around the machine. It is possible that the unity of the mother/baby can be estranged as the focus of attention turns away from an inward oneness. Montagu's (1971) notion that "the uterine contractions of labour constitute the beginning caressing of the baby in the right way" (p. 72) may seem strange in thinking of Christine's experience. It would be hard to feel contractions as "internal caresses" of the baby while listening to or experiencing one's baby in a machine.

Wendy also found the monitor extremely helpful. "It was just numbers you could see on the monitor," she said, "but I knew that the baby wasn't in any kind of distress, that she was coping well with the contractions" (W). So although she originally did not want to have the fetal monitor attached, she found it reassuring for herself to know that her baby was fine. She did not have to depend on the staff to tell her about the well-being of her baby.

But the baby in the machine could be a source of confusion and fright for women. Melissa said, "It [the monitor] wasn't functioning particularly well either, which was a drawback. It kept going to its emergency BEEP, and it sounded very ominous, and it would go beep and she [the nurse] would come tearing in to see what was wrong. Our reaction was to say that it is something with the monitor, not with the child" (M).

In spite of the drama of hearing the heart beat telling the mother, father, and attending staff about the health of the baby there are other, less obvious, things that are also occurring. By focussing on the machine there is less attention to the woman and her experience by all—doctor, husband or partner; and perhaps even the woman herself. "The danger of technology is that it tends to cultivate insensitivity, a clinical detachment, a deadening of emotions," said Blumenfeld. "And nothing is more dangerous to human survival than that, for our emotions are our survival instincts, and when we shut them off we begin to lose our way, to be less human" (1975, p. 195). At the same time it needs to be remembered that the fetal heart rate is a first indication of problems needing prompt medical attention which can save the life of the baby. It is a matter of how the "listening for the baby" occurs.

Welcoming the Baby

> Then the family stills to view one of the truly astonishing wonders of life: the first breath. As Jonathan takes his first gulp of oxygen, his complexion slowly warms from an eerie blue to a glowing pink . . . The joy of the family is palpable. They fuss. They adore. They coo. Jonathan responds . . . he is wide-eyed but lies serene in mother's arms. (McRoberts, 1984, p. B9)

"How wonderful!" "The way a birth should be!" "Of course!" The description of this baby's first breath was recorded by a newspaper reporter who observed Jonathan's birth at home with the attendance of a midwife. Baumgarten (1981), an obstetrician, and a proponent of universal fetal monitoring, agreed that the first minutes of life of a newborn infant are most important but argued that the "real" importance is "[physical] warmth, a normal Apgar score, and a high umbilical cord pH" (p. 271).

Let us say that both voices are referring to Jonathan's birth. In each approach we accept an underlying goal of a healthy baby and mother. In the reporter's version we see respect for the wonder of life (a baby's first breath), the response of a family (palpable joy), the response of Jonathan (colour change from blue to pink, wide-eyed, serene) in the mother's arms (the woman who is now mother). The obstetrician's account—the goal of environmental warmth (possibility of a warm blanket, or an incubator), a normal Apgar score (evaluation of the baby's heart rate, respiratory effort, muscle tone, reflex irritability, and colour), and a high umbilical cord pH (blood sample taken from the cord at time of birth)—has lost all trace of Jonathan, his mother, or even a respect for the wonder of life. What is heard, rather, is measurement and calculation in a vacuum of any human interaction.

These two views of the first few moments of life show a divergence in the forms of knowledge used to welcome the baby into the world. The target of a "normal Apgar score," or the desire for "first breath in the arms of a mother" influences the knowledge and tools used to attain the intended goal. Conversely, the tools and knowledge used influence the result itself. On the one hand, if what is seen as the important outcome is the beginning relationship of Jonathan and his family there is a standing back on the part of the viewer (professional). The professional allows the interaction to unfold, while maintaining warmth, watching the colour of the baby change, and noticing the baby's response to the world. On the other hand, if the important outcome is a fixed quantitative, measurable value of the umbilical cord pH, then the mode of experiencing will also be quantitatively, technologically colored—using measures, and scales which need professional intervention and direction. This example shows the difference between meeting the world "in the flesh" (based on knowledge of human relationships) or "through machines" (based on knowledge of efficiency and measurement). Both outcomes can be in the interest of the health and safety of the mother and child but the criteria for reaching toward that safety has to do with the whole context in which the health of the baby is sought.

The moment of birth as a community event seems rather strange when we consider most births in hospital where only one companion is allowed to accompany the birthing woman. Jane's mother had wanted to be present at Lisa's birth but, even in a birthing room, Jane could have only her husband with her. Nevertheless, Jane's mother slipped in, uninvited, to see her daughter and granddaughter within minutes of the birth (J3). For the moment of birth, the mother is generally surrounded by strangers—nurses whose names Christine could not even remember (C3). If the birth were at home there is more likelihood of a community of people—husband/partner, children, parents, friends, as well as the midwife (recall Paula's home birth described in chapter

1). Obstetrical practice discourages observers in the delivery room (partly due to mounting number of malpractice charges) while midwifery practice encourages the presence of family and friends. It was not long ago that husband/partners were relegated to waiting rooms to be given news of their new child's birth and the mother's experience from the doctor or nurse.

In reminiscing about the impact of the birth experience in our lives, my husband and I often remember Michael's birthday. He was born in hospital one Sunday afternoon about three. His brother, Ben, had spent the day with us and we expected that Ben and his father would join us for supper. Much to our surprise and delight, Michael, his mother, and his father came to join Ben and us for supper. Here was a newborn baby in our home. At two or three hours of age, he was a wonder! How would we have felt if we had been at his birth? I think of Michael in a special way because of sharing those few hours on his birthday.

Could it be that as a society we seem to be losing our sense of the importance of children, in part, as a result of our clinical separation of the moment of birth from the context of life? "Just as the exclusion of birth from the larger context of life has diminished the role of contextual knowledge, so the disappearance of knowledge of birth as a social event has contributed to the disappearance of the event itself: childbirth has become an inconvenient disruption in a life dominated by work and leisure" (Böhme, 1984, p. 381). If the moment of birth has the power to transform individuals who participate in it, and if birth were considered an important community event, it may no longer be seen as a disruption in life but as an opportunity for relationship and celebration. Knowledge used at the moment of birth influences how babies are welcomed into this world. How we welcome babies into the world affects how children are seen and cared for (chapter 8).

Development of Knowledge and the Experience of Childbirth

The birthdays of my children are often times when I talk about my experience of their births. I describe the day, when the contractions started, where I was, when I decided to go to hospital, what they looked like at birth, who was there, and so on. Although I tell their birth stories again and again, each telling is exciting for me, and, I think, important for them. It is a transforming story: one that changed my life.

Yet the stories of births are not merely individual experiences that many women share. The stories of birth show how women come to understand themselves, and how women come to understand themselves is a larger issue than attention to individual stories would suggest. It has to do with how women come to understand the world thus influencing the very foundations of forms of knowledge. It may not be incidental that obstetrical knowledge has been tied to male-stream, objective, abstract thought, nor may it be incidental that midwifery knowledge is tied to women's experience of reproduction—as a normal process of a woman's life. It would be interesting to explore, in depth, the nature of methodological approaches such as the Lamaze method, developed by a male and father, or Kitzinger's approach, as female and mother's view. They may indeed be seeing childbirth from two different views and develop different knowledge as a result of these different views.

If O'Brien (1981) is right that male reproductive consciousness (as fathers) influences men's ability to think in abstract and objective ways, further exploration of women's reproductive consciousness (as mothers) may provide forms of knowledge that swerve away from detached analysis to approaches that are tied to concrete experience of relationship and integration. Such approaches to knowledge may avoid the polemic of mind-body, subject-object, natural-technological, masculine-feminine or obstetrical-midwifery. Knowledge that integrates mind-body, subject-object, nature-technology, may also come to be seen as valuable in learning more about living as humans in this world. Coming to an understanding of women's experience of birth, as a process of transformation, is one way to begin to open up the need to question our attachments to forms of knowledge and to reassess current practices of childbirth.

Chapter 10

LIVING THE QUESTIONS: ONE IS WHAT ONE DOES

Introduction

The transformative experience that is accessible to women who become mothers has been the central focus of this study. The conversations with women have opened ways to explore what it means to become a mother, forcing a questioning of the forms of knowledge used by women to understand themselves as mothers. Being a mother is a matter not only of the mother role (Barber & Skaggs, 1975; Wolkind & Zajicek, 1981), not only of caring for the child, not only of caring for a home. It *is* a matter of a changed understanding of who women *are*, as mothers. Becoming a mother is a matter not only of maternal tasks (Rubin, 1984), not only of developmental tasks (Valentine, 1982), not only of stressors and satisfactions (Wilson, 1982). It is a realization and acceptance that "I *am* a mother."

Of course, no woman's life is exactly alike, as demonstrated by the stories of Brenda, Christine, Jane, Susan, Anna and Katherine. Each woman is individual and her appropriation of this phenomenon is unique. The themes, the moments, that emerged from individual lived experiences, were developed in a dialogical way so as to explore the meaning of the moments for other women as well. As I entered into a relationship with the text of the stories, the transcripts (of these six women and many others), literature about childbearing and mothering, other phenomenological literature, and my own experience, the search for understanding of women's experience became broader than the unique meaning of individual lives. Yet the individual experience made it possible to see the importance of the broader issues.

The orientation in the approach to the texts has been to search for an understanding of women in a way that acknowledges the public reality of women's private lives. This public/cultural responsibility is realized in the care that pregnant and childbearing women receive. The hermeneutic thrust of this study has aimed at producing a text that reveals a strong version of women's lives, one that shows the possibilities as well as the difficulties that childbearing brings. In the attempt to understand (by writing, reflection, and re-writing) there is an underlying recognition that the depth of human life may become flattened, simplified, and even polarized, in such an attempt. The goal has been the opposite—to write in a way that reveals the layers of complexity of human life in present society. With women's changing understanding of themselves this revealing has challenged existing notions and explored new ideas.

Exploration of issues of meaning (questioning human values) sometimes may seem to focus on the extremes. This attention, to the unusual, could be criticized as a one-sided pointing to the problems of one viewpoint while disregarding the problems inherent in another. Therefore, on the one hand, in bringing the less dominant approach to childbirth knowledge and experience to light, there is a danger of overstating the situation. On the other hand, it is primarily because there has been a dominant, one-sided practice of childbirth that the critical effort to create a more balanced view (while seeming to distort) may be necessary. As I write this final chapter, I recognize that in many ways the question of "How can I understand women's transformation to mother?" is still present. However, all questions of this nature are, in reality, ongoing. Women's lives are constantly changing as they learn to understand themselves in new ways.

The close relationship that exists between question and understanding, between showing and hiding, is what gives the hermeneutic experience its true dimension (Gadamer, 1977). The text has revealed many aspects of women's lives in tracing their transformation to mothers, yet what may be essential to this transformation may still remain hidden. What has been learned? What does it mean to be a mother? These questions demonstrate the open-endedness of this research. So, in a sense, it *is* not finished. It *cannot* be finished.

The questioning goes on. For me, "living the questions" of this dissertation has invited reassessment of my relationship to the nursing profession profession—and has brought me to a renewed commitment to being a nurse. "Living the questions" has also forced me to reassess my responsibility for actions which include how I live as a mother to my children. Living the questions forces me to think about what I have done. Recall the birth of Suzie, Brenda's baby (Chapter 3). Her father and I could have picked her up and welcomed her to this world. The nurse-midwife could have spent those few minutes helping the father reach for the child he watched so attentively. The doctor could have talked to the baby and her parents in ways that would have encouraged a celebration of this important moment. Not one of us did anything. We carried on with our procedures, our charting, and our watching. Everyone felt uncomfortable that Brenda could not reach out to her baby, but we did not do anything to assist her. I did not do anything, and this knowledge leaves me troubled.

The Question for Nursing

As I think about nursing I think about Florence Nightingale. What can be learned from her example? Florence Nightingale has been immortalized as "The Lady with the Lamp." Apparently, though, Florence was also called "The Lady with the Hammer," for during the Crimean war in Turkey she needed to use a hammer to break down the store-room door in order to get supplies to carry out her nursing in the military hospitals (Kramarae & Treichler, 1985).

Recall the ancient, pre-Christian myth of Eros (Amor, Cupid) and Psyche. The myth, which is a product of the collective imagination and experience, portrays the human condition with indelible accuracy (Johnson, 1976). Beautiful Psyche was married to the god of love, Eros. She lived in paradise, happy to be loved by Eros who, although he would not let her see his face, came to sleep with her each night. By listening to her sisters, Psyche became convinced that she needed to see the reality of Eros. She needed to see his face. One night she took a lamp—and as she lit the lamp, she saw his beauty—"the most beautiful creature in all of Mount Olympus"—and fell in love with him. In her attempt to get near him Psyche awakened him with hot oil spilled from her lamp. He realized what she had done. He left her. Psyche, then, had to win back Eros's love through her own work—through various tasks and difficulties.

"The symbol of the lamp in the myth points to the light-bearing capacity of women," said Johnson, "In the Eleusinian mysteries, the women carry torches, which shed a peculiarly feminine kind of light. A torch lights up the immediate surroundings, shows the practical next step to be taken" (1976, p. 27). The word "lamp" comes from Greek *lampein* meaning "to shine." A simple device, one could say. Yet in its shining the lamp lights the way, shows the next step, lights up the immediate surroundings, even shows the beauty of the situation. The lamp associated with Florence and Psyche was a hand-held lamp. In order to show the way the lamp needs to be carried by the nurse. She cannot send someone else. She must "be there a nurse" (Olson, 1986).

The nurse has sometimes been thought of as a mediator, a "go-between," for the patient-doctor, the patient-family, or the doctor-family. Some have resisted this notion of nursing as a weak position. To find a stronger version of mediator one could look at the example of the Christ—who according to the Scriptures, was a true mediator between God and human beings as the "Light of the World," the "Word made Flesh," the "Way, the Truth, and the Light." A mediator provides the favorable environment so that the individual can work out his or her own life (think of a mediator in a dispute). To be a true mediator, the nurse needs to use her knowledge in a way that provides the childbearing woman with the environment to undertake her own project of transformation. Florence, the lady with the lamp, reminds the nurse to *be* there, with a light to show the way, to illuminate the dark space, to provide a circle (of support) in which the woman who becomes mother can do what she needs to do. The nurse, with a lamp, can even show the beauty of the ordeal—by being there. The lamp reminds the nurse what one must be.

Florence used the hammer in order to do what she needed to do. The hammer is a tool for destruction and building. Nietzsche also talked about the use of the hammer—~~called his~~—"philosophy of the hammer"(Morgan, 1941; Kaufmann, 1968). Nietzsche's hammer was "intended to smash what is rotten in humanity and hew out what is sound" (Morgan, p. 357). Nietzsche was reacting against the "vast social machine in which individuals are equal and trivial parts, [where] everything is means, nothing an end," leading to "safety, comfort, and mediocrity for everybody" which he called a slow stagnation (Morgan, p. 354). He was striving for a reassessment of all values. He wanted the conscious (those who saw the situation) to become courageous, the silent to become outspoken, in order to bring to illumination the true nature of traditional values (Kaufmann, 1968). "Florence with the hammer" reminds nurses that it may be necessary to tear down those structures which interfere with personal growth and responsibility, and to destroy that which holds individuals to consider only the expedient rather than the meaningful. The hammer can also be used to build a society, a nursing environment, that is not machine-like, but to build an environment that appreciates individual uniqueness and individual projects of living. The hammer reminds the nurse what one must do.

Concluding Thoughts

While thoughts of the lamp and the hammer, of being and doing, can be helpful, the project of "living the questions" raised in this work is not easily carried out. It means keeping open the search for understanding, constantly questioning what is taken as secure, accepting the fact that there is still more to learn, searching for another view of the complex reality of living—which may open further depths of questioning and understanding. It means, also, keeping open the conversations among women, between groups of women who tend to polarize women's issues such as particular feminist groups and pro-family groups. It means keeping open conversations among women and men about unique and shared ways they come to their experience of parenting. It means keeping conversation open among nurses, midwives, and doctors to explore forms of knowledge appropriate for each situation while trying to avoid attachments to knowledge for technical, market place, sexist, or economic reasons. It means continuing dialogue between the differing activist and professional groups such as Safe Alternatives for Childbirth, the Task Force on Midwifery, and the College of Physicians and Surgeons. It means keeping open questions of how women live as mothers in dialogue with questions of the place of children in society. "Living the questions" is an ongoing project.

Conversation and discussion about the significance, the possibility, and the consequences of differing approaches to childbirth knowledge are needed in order to change attitude and practice. This is not the place to advocate solutions to the problems raised in this work. Simplistic solutions will not do. I hope, however, that this study may help in the process of clarifying the social and medical issues, the personal meanings, and the taken-for-granted childbirth practices needed to produce productive dialogue. In the following section of this chapter I aim to present theses derived from the present study that could be seen to be necessary suppositions for the continuation of dialogue about knowledge used in childbirth education and practice.

THESES

Giving birth to a child is a transformative experience for women.

One can "have a child" without truly becoming a mother.

Policies regarding childbirth practices need to include the recognition that childbirth is a transforming experience for women. Planning for the health and safety of the mother and child needs to include recognition of the woman's own experience of becoming a mother.

The decision to become a mother is more complex than the rational decision-making process can encompass.

To make a decision to bring a child into one's life is to enter into change that one cannot really comprehend. The decision to have a child is beyond mere problem-solving.

Having a home for a child, is to take on a new responsibility for the world—the world as a good place for children.

Childbirth is a sexual experience, not just at conception but throughout pregnancy, birth, and nourishment of a child.

Deciding to accept a child into one's life is an ongoing decision. It must be re-affirmed at various times in the growth of both mother and child.

The intertwining presence of the child in a woman's body needs to be held sacred at all times during pregnancy and birth so that the woman can experience her own change through this unique relationship.

The process of becoming a mother for a woman who adopts, fosters, or hires a surrogate, may be different than for a woman who "carries the child beneath her heart." Exploring different experiences may show the significance of each in a clearer light.

The pregnant woman is changed by the presence of the child. While maintaining all her own projects of living, the pregnant woman is also growing with her developing baby. It is a healthy, unique, bodily experience.

Maternity clothes need to support a woman's move to mother—helping her to accept and feel good about her growing body as a sexual and powerful being.

The vulnerability that a woman begins to feel in pregnancy is not a sign of weakness but a sign of the increasing need for her relationship with others. A woman "with child" is a community responsibility.

The time-table approach to pregnancy and birth denies the individual variations in this developmental process. Care needs to be taken to ensure that normal, individual variations are not seen as pathological.

A woman "with child" experiences a changed approach to the world. Becoming a mother begins with this changed view of the world.

The separation of the mother and child through labour and its pain offer the possibility of *integration and wholeness for both woman and child.*

Pain is not always negative. It can be healthy, and lead to personal growth.

Childbirth pain cannot be compared to the pain of illness. It is different. It produces a child.

Women need support to deal with their pain through a number of ways, finding a good position, making noise, being themselves, having familiar people and things, breathing patterns, as well as medication. Support should be given, without asking, in all birth environments—hospitals, birthing rooms, birthing centers, or home.

The rhythm of labour can be useful in helping women deal with their pain. Learning to get in touch with their own bodily rhythm can prepare women for labour.

The place of birth, be it hospital, birthing room, birth center, home—needs to be an environment where the fullness and richness of the moment of birth can be experienced.

"Being in pain" is an inner process of women that must be respected and supported.

The separation that occurs in childbirth makes possible the wholeness of both mother and child. Separation is not a negative process, but a necessary occurrence that is gradual and, probably, never complete.

The experience of childbirth may bring women closer to other women, as well as to partners and friends, who are a part of this sacred human experience.

The responsibility of becoming a mother belongs to women. All procedures, techniques, and interventions, to the woman or child, need to consider and support the acceptance of responsibility on the part of the mother. Responsibility must never be usurped by others.

Responsibility for the life of the child contains the possibility and impact of death.

Giving birth is women's responsibility. Taking that responsibility is an opportunity for growth. Labour is a necessary and valuable experience for women. If women are not able to "give" birth, they need to have the opportunity to reflect on their own experiences with those who assisted with the birth.

Preparing to take responsibility impacts the moment of birth.

As a part of her sexual nature, childbirth for women should be seen as the opportunity for fulfillment and satisfaction.

To be responsible for the world begins with the recognition that women's experiences may not be fully valued and respected.

To be responsible for the world includes attitudes that will empower a girl/woman rather than restrict her.

To have a child on one's mind is to be a mother. Support for women who are mothers is needed so they can care for their children in the best way possible—through shared parenting with the child's father or other caring adults, supportive child care arrangements, flexible work hours, shared job *opportunities, etc. Women need support to mother their children.*

To have a child in one's life is a blessing.

To have a child in one's life forces one to think about how one should live.

To have a child in one's life means one no longer is able to live only for oneself.

This particular exploration of women's experience of becoming a parent brings to light the need to explore men's experience. Parenting is a shared undertaking—parenting by both mothers and fathers is needed by children.

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APPENDIX A

References re: Interviews with Women

Interview data for the six women who provided the primary source of data:

Anna (A) October 15, 1985 (A1)
December 2, 1984 (A2)
January 31, 1985 (A3)
February 7, 1985 (A4)
March 24, 1985 (A5)
September 28, 1985 (A6)

Brenda (B): October 28, 1984 (B1)
November 26, 1984 (B2)
January 16, 1985 (B3 - birth)
January 21, 1985 (B4)
March 29, 1985 (B5)
November 1, 1985 (B6)

Christine (C): February 17, 1984 (C1)
March 29, 1984 (C2)
April 19, 1984 (C3)
June 2, 1984 (C4)
October 5, 1984 (C5)
March 14, 1985 (C6)
October 16, 1985 (C7)

Jane (J): February 16, 1984 (J1)
April 5, 1984 (J2)
May 31, 1984 (J3)
October 11, 1984 (J4)
March 30, 1985 (J5)
October 16, 1985 (J6)

Katherine (K): September 17, 1984 (K1)
November 7, 1984 (K2)
January 2, 1985 (K3)
February 14, 1985 (K4)
November 2, 1985(K5)

Susan (S): October 15, 1984 (S1)
December 15, 1984 (S2)
January 31, 1985 (S3)
February 14, 1985 (S4)
March 21, 1985 (S5)
October 30, 1985 (S6)

Women interviewed for an earlier version of Chapter 6:

Diane (D): February 4, 1983
Ellie (E): January 8, 1983
Flo (F): February 12, 1983
Helen (H): January 8, 1983
Iris (I): January 9, 1983
Laura (L): February 5, 1983
Noa (N): January 25, 1983
Victoria (V): January 22, 1983
Xavier (X): February 2, 1983

Women interviewed for an earlier version of Chapter 9:

Melissa (M): December 10, 1984
Natasha (N): December 8, 1984
Opal (O): December 14, 1984
Una (U): December 13, 1984
Wendy (W): December 17, 1984
Yvonne (Y): December 13, 1984

Others:

Gail (G): August 8, 1986
Paula (P): May 7, 1983 (P1)
May 10, 1983 (P2)
January 6, 1986 (P3)
Ruth (R): January 28, 1985
Theresa (T): March 12, 1985

APPENDIX B

These three transcripts were chosen to show the nature of the conversations with the women, and to show how the content of the conversation changed over the period of time. The transcripts have been edited for style only, for the purpose of clarity. I (V) spoke with Christine (C) seven times over the period of the study: *February 17, 1984 (C1)*; March 29, 1984 (C2); *April 19, 1984 (C3)*; June 2, 1984 (C4); *October 5, 1984 (C5)*; March 14, 1985 (C6); October 16, 1985 (C7). The following exemplary transcripts are those from the dates italicized above.

February 17, 1984

C: I think it is pretty relevant to talk about where I was at even a few years ago in this decision because it has really colored how I have perceived or the things I think about in pregnancy, and it may be a difference because of that. We had a very difficult time making the decision to have a child, and that was on both sides, for sure, at least up until the time I was 30, I'm 32 now, because I was quite concerned and adamant that I wanted to do my work and my work was really important to me, and to fulfill some of my ambitions, at least to 30 years old. It never was that having children was not a good thing to do. My experience as a child, having been parented was excellent. I saw in my parents that having children had been a good thing in their life, had really fulfilled them and I had happy relationships all through my childhood, so I didn't see it as a negative thing just that this isn't a good time, the right time.

V: Was there always the idea that you would have children then?

C: Possibly in the back of my mind, Vangie, but because I knew my husband was coming from a whole different background, who thought that maybe having kids was the biggest mistake anyone could ever make in your life, that it was difficult for me to just blurt that out knowing how he felt, because he was very important to me too. I thought that we have to make this decision together, we have to both want this. And I think of how my relationship is with my husband that came into saying well maybe I won't, and is that O.K. and I thought that that would be alright. Once I turned 30 then my urgency came to a head in that I have to decide, I can't just go on. What I don't want to do is not decide and come 36 or 37 and feel that the decision has been made. I don't want to make the decision that way. So I put pressure on my husband which he didn't—pressure for a decision and he didn't like that very well, it was very hard for him and because you put your relationship into jeopardy and we had some pretty heavy duty times there for two or three months when we had to decide this. In fact we went to a third person as a counsellor just to say, "We need you, not to help us make the decision, but mediate us making the decision," and it was a very good thing to do and my husband, he was very supportive of that. The decision was so emotional for us that when we started to try and make the decision, I would be in tears and Nathan would be so up tight, we said, we just can't do this.

V: Was that because you had already made a decision that you wanted children or?

C: I see. Yes, I think that Nathan perceived that I wanted to have children and I kept saying to him, "That probably would be my choice, Nathan, but what I really need to decide is to what you want, You've got to tell me what you want, and then we have to say, can we live with that. Can either of us live with either making the decision that wasn't really theirs." That was so hard because Nathan, I think, was struggling. He was more on the fence, but he knew that the my bottom line was, yes, I would choose to have kids, and he felt like I'm holding everything in the balance here and that was very, very hard for him. So we—Nathan went and talked first, all by himself, which I thought was very, very good. He wanted to go first and speak to this person and let him know my perspective and it was quite a good experience. It was an excellent experience, but I think the guy sure didn't work hard for his money (laughs). I'm laughing because I think we communicate very well because it just needed to be so I wouldn't cry and Nathan wouldn't get tense. And I cried anyway but it seemed to resolve itself. So it was a very good thing to do, and so then we could decide, and Nathan decided, yes, this was o.k., and we will go ahead and have a family. Still with hesitation. I can remember walking the dog after we had been through this, and the relief I felt and Nathan said, "Well, how do you feel?" (quiet voice) "Aren't you afraid?" I said, "Yes, I'm afraid, and having made the decision doesn't mean that you don't have doubts" and he said that was good to know!! And then that was behind us. But once we conceived I was really anxious to know how Nathan would react, and how I would react and I had a—it was very scary for me. When I was only a very few weeks pregnant, I had a bleeding episode. I was so upset, and Nathan, I was in Ontario, and Nathan had just arrived and I hadn't even told him I was pregnant, and here we were swimming and I went up to the cottage and I called Nathan up and I said, "I'm pregnant, but don't hold your breath." He was very shocked and said, "What shall I do, what shall I do?" and I said, "Nothing, just me lay here and go down to my friends and carry on". I was very upset, after finally making the decision, and now what if I couldn't have kids—went through my mind—and it past and was fine. I bled for about 2-3 hours. I went to the doctor in Ottawa, and he said everything looked fine. I wasn't encouraged and was depressed for about 3-4 days, and my Mom was concerned about me. But the difference between me and Nathan was amazing. I thought, "Oh, was the baby alright?" and Nathan had decided that if I had stopped bleeding then every thing was alright, and oh well, the baby is fine, but I said "Well, how do you know?" But he was convinced that the baby is fine, you are fine, and everything is going to be fine. And it never occurred to him and it still doesn't, that anything was going to be wrong. And I said, "I sure wish I had your faith."

V: You know too much.

C: Yes, I think so. Nathan was quite delighted, he laughed with my father, and my parents, and was quite, in his way, overwhelmed with it.

V: You knew?

C: I knew. I was using my temperature chart as birth control, Vangie, and could follow it quite closely so—in fact, I had to convince the doctor that I was pregnant. I was late, and I never was late, and I felt confident, having read my chart, that if everything was normal, I had conceived. I did not feel any different other than a heaviness, but I would feel that pre-period, anyway. But I knew. The doctor didn't believe me but I asked him to treat it as if I am because I am.

V: So Nathan didn't know?

C: I had been home for almost a month, and I was just a week past due so I was thinking that I was pregnant but I didn't want to tell him on the phone. I wanted to tell him when he got there. No one knew. My Mom was really concerned. And I saw doctor in a neighboring town, and she was British and was a lady, and she had several children, and she had miscarried several times, and she was really, really good, and was very encouraging, and she said that my belief is that is that is you are to miscarry, you will if you are standing on your head or not and she said, don't do these things, but carry on and I said, "I will", and I did. I just didn't do foolish things. (discussed the possibilities of why it happened) But it was very scary. Once I got home and I saw my doctor. I had ultrasound at 11 weeks, which is just interesting—interesting for Nathan too. The baby was all there, all whole, the head, two arms, and the placenta, and I was glued in on the placenta, I wanted to see where it all was. Nathan was really thrilled. So maybe it came real for me before other people, because of that. Up to that point I felt tired but I didn't feel pregnant. We discussed ultrasound with Dr. Henry, but with this, "Where we can make something past history, I can recommend that we have it done." And I agreed because I needed to put it in the past too. So it was very relieving for me and brought everything into focus more and certainly for Nathan. He thought that was really quite neat to see everything. You can talk to him about embryology but it is different when you can see it all in one piece. I don't know what he expected to see but it was very human like, and that was good for him. Since then I have not had very many thoughts about the baby being abnormal. I can listen to some awful things and it doesn't bother me. I haven't had problems.

V: Did other people know by that time?

C: I told a few friends and only one person on staff here, told Alice. In case I didn't show up a work one day, so she would know what happened. When I finished my first trimester I told people, I felt I could have told people a way before then. I told my boss actually. I was quite happy to tell people. Many of our peers, all 30, all trying to decide to have children, and 3 or 4 are now pregnant. Now we are all expecting, and that is delightful from my point of view and certainly from Nathan's—to have people to share the changes in all of our lives. We have spent a lot of time together doing common things. Now a whole bunch of us are making this shift at the same time. And I think it is really important that you have people with common experiences and you can help each other out, and talk about that. The first three months, first 16-17 weeks, I didn't feel so well—tired. Yhat is the hardest part, I felt very exhausted. Oh, and I was studying and the first semester is hard Here we go again. The second semester always seem easier for me. It might not be it just seems that way. So it was heavy studying and heavy going, very tired, and not feeling so well. I didn't have a lot of throwing up but I had my share. And uh, once I got beyond that, it went so well—after the three months, 16 weeks. I felt [I had] lots of energy. I swim three times a week, and I felt so good. I had my energy renewed, more or less back to normal, and the physical change is really neat. I was talking to my staff about this. I find it hard to listen to one of my girlfriends, for example, to hear her talk about feeling fat and not very attractive, and that is very hard for her—how ugly she feels. I just don't feel that, I feel so good. The physical changes are really neat, and I have the—my husband feels the same way. With lots of positive reinforcement about how that looks and how it feels. He'll joke but it is a very pleasing thing for both of us. The change in my body is not an awful thing, so I find it so hard to relate to people in general, and especially this girl friend of my who find it so hard. I guess it has to do with how we see our bodies in the beginning. I know she is very conscious of being slim, and her husband is conscious of her being slim, so maybe it is very hard for both. And you think about your whole sexual relationship and how that changes and how it is different. But it has been an easy thing for us to go through, without much stress. It feels nice and hard and that is just a nice thing.

V: You are not fat either, and maybe you never have been.

C: No. You are quite right, if I weighed 50 lbs over—I've gained 20 lbs. It is about right. I have 6 or 7 to go. I've kept track, and that is fine. In fact, I was worried about not gaining.

V: Have you always felt positive about you body, have you always felt good about it?

C: I think that is fair to say. I was always big and weighed more than my girlfriends. But it was always—my mother won't let me dwell on it. She always encouraged that you eat well and not over-eating and that your body is—you have to be able to use your body and it has to work for you, and you need good food to do that. I think generally I always felt go about my body. Well, I didn't want to gain too much weight, relative to my bone structure. That I know is different than my girlfriend did. I think it is a marvelous thing, and that is reinforced by my husband whom also thinks it is fine. He would joke but just his caress would tell me that this is a nice thing and not a horrible thing, so he says it as well as shows it I wanted to make sure you get about the change in my relationship with my husband and this was certainly part of our uncertainty, and probably more Nathan's than mine although I would be a fool to say I didn't worry about that. We had ten years before this baby is born, that is a long time to be without another being with you. Nathan had ~~had~~ such a poor idea of what a family could be—that when he got married he couldn't believe that one could have such happiness from being with another person. That became very dear to him as it is to me. But my attitude was, "Of course, this is the way it is supposed to be," whereas his was—I'm so amazed. And it is not without work and without it's ups and downs. I don't want to make it seem that it has been an easy thing with us, because it hasn't. But I could see him saying that he did not want to change this because of the unknown, it will smash it all up. I said, "I see it as being better, Nathan," and he could not see that, specially when he thought he now had something that he feared would go away. It was really hard for him and for me too. It will be interesting to hear me after the baby is born. I will tell you some of my fears about what I will loose as a women, my career. It is interesting to see the change and development in a relationship that you thought you knew really well, and that is always so nice to know. And Nathan talks about what his responsibilities are, or how it makes him happy to think about this or that. He has been "nesting," making up the baby's room and those cupboards, and get this all in order, and thinks about the kind of car I'm driving, because you have to put this car seat in and out. The things he thinks about, I'm so amazed, the things he now takes into consideration. Having been so hesitant before—just the closeness and the change in the relationship that way. I feel at a loss for words to tell you the difference in our relationship but it is a very significant change, in closeness. I've talked about some vulnerability in being dependent and more reliant [on others]. The first time in his whole life he said "There is ice on the walk would you watch it." I laughed, it is small little things but it is a way—a concern he never had before. It has always been, Christine can look after herself, she is strong, and independent, and can do whatever she likes, and she has the strength to do a lot. It is the first time in his life he has ever, ever, ever said that.

V: How does it make you feel?

C: It feels good, and it makes me smile. Of course, I think about it too. Before I just charged across the road, now I don't, and I've done it. I've changed and Nathan has just slipped into it.

V: What things in your everyday activities, in your work have you noticed a different?

C: Certainly in the way I stress my body. I wouldn't mind lifting or stretching, I wouldn't even think about it. I wouldn't have anyone do that for me because I could do it myself. I have never been endeared to having people open the door for me, or those kind of things, as if opening the door isn't something I still do, but I'm very aware about lifting things and using my body correctly to lift. But I am very conscious of bending correctly and lifting correctly, and I think about how much something weighs. I get the grocery guys help me out with the groceries, I never did that before.

V: Did this change over time or did it start right at the beginning?

C: Yes, it has changed over time. Certainly in the first 3 months it never even occurred to me. Just in the past six weeks I've been more aware of it. Nathan has made the change over time too, but I just giggle, I just laugh.

V: Do others do that to?

C: Oh, yes, and far earlier than I think they ever should. They go over board more than I think they should. There are a couple of guys in Nathan's office and when I come into the room, (very old fashioned), it's—this pregnant lady has entered the room—as if you are something special, very much in awe. They are very uh, well, she's pregnant, sit down.

V: Do they stop smoking in front of you?

C: One fellow has, people are more conscious. One of my staff, we had a blow up, as you do every now and then, about smoking in the staff room, it is a too small coffee room. We live with the two smokers. I talked to one person who I knew was quite upset by it. She said, "I just can't stand them smoking with you in the room, how can they do that?" It hadn't occurred to me, to tell you the truth. I knew about secondary smoke and that, but I hadn't seen it as part of the problem. This one person was very upset that they could continue to smoke when I was in the room. My decision is that I would leave the room, but she thinks they should not do it. People have certainly treated me differently, well before I thought they should. And some things—I don't think you need to do that.

V: Like what?

C: Just normal carrying of things, or helping to move a table, it is ridiculous. I can still do that. But there are other things that are reasonable. Nathan is a real handy man, and with this nesting, he is fixing everything, so he has been bringing home all this lumber and gadgets. Before I always dreaded it because I would be hauling it in, and helping him bring it in. Now he doesn't even ask me, and I'm so glad. Those kind of changes. and in changes in what your body is for. I think it is different, even sexually, he says it is harder to think of me, uh, it is a different thing now—the desire for you. You now see that these parts have a real biological function, it is not that you don't know that before, but it is so obvious and evident now that this body is made for this, and designed to accommodate that. It is interesting for him to talk about it. We have always talked about what makes you feel good and not feel good. That has always been a fairly open thing for us, and I just, I noticed a change, and I said, "Do you feel differently?" and he said, "Yes, I do, but it's not that I like you any less, or desire you any less, (he wanted to make sure that wasn't the case), but I just feel different about what the vagina's for, and what the breasts are for," and he sees that different. Women have children, and parts have definite functions in that. It hasn't taken away, it is just different. So the changes in my body have not been a negative thing for us. So it has been such a nice thing, that after having such difficulty making a decision, that so far, it has been a delightful change. One wonders what, when the final product is here, that is the big change. But these have all been encouraging and positive signs for me that we both didn't know.

V: You've seen other parts of each of you that you didn't know was there.

C: Yup. Sometimes it makes me feel more vulnerable that I feel more dependent, that I feel, sometimes I worry about the extra load that Nathan must feel. It has been very equal partners in sharing in the household income and the expectations of working together for certain goals, financial or otherwise. I've been lucky to share pretty well equally, and I wonder how I would feel if I were the only breadwinner, especially in these economic times. We are prepared financially to have our income cut in half.

V: Are stopping work?

C: For a least a year, my leave is nine months, and I probably would extend it to a year—maybe more than that, with school and all. Mind you that can change if it had to, but I would be disappointed if it had to. Uh, we've planned very carefully, probably more carefully than most people. But still, I think about that, and know Nathan does, not so much financially. But he wonders about how different it will be with me not working and it's going to be different to be home with this baby.

V: Do you think about it?

C: Yes, a lot. A lot of my well being has been tied up with my work which I really love, and even though everyone tells me that mothering is important and good and can self-actualize parts or different parts, or more parts of you, it still concerns me.

V: What about the giving up the money, your own money?

C: Oh, that is not hard for us, I think, the life the style change, not being able to go camping, our life style is pretty cheap, except for skiing, but our life style change will not be effected. We are not giving up or trip to the Bermuda's. We have always had a joint account, it has never been my money or your money, it has always been our money, it is still the common pot, just half. It is the extra responsibility on Nathan to be the person that has the income here. It is particularly pertinent, now, because Nathan has started with a fairly new company, very high stress, "Is this really what you want to do, Nathan?" and I'm afraid that he will say, "No, it isn't but I better do it anyway, and I don't have a choice." I'd hate for that to be, and then on the other hand, what if it isn't good, then you have to get out. I would be forced to go back to work and I would feel badly about that.

V: Would he stay home?

C: Yes, I think he would. We have talked about that. On any given week he feels very drained, and is wondering, "Is this good life choice for me, and I would rather he get out now, or before a dreadful two years." It doesn't worry me, and I'd feel alright about the child because you'd be home. The only disappointment would be me losing out on something I am looking forward to. But I'm sure I could handle that, I'm sure I could, in fact, it may be a really neat thing to have happen. I have a feeling about men staying home with their children and how it can really teach them a lot. It may be go to take a leave, even a short leave, and try it out. But, we've talked about that and that would be a big unknown. Nathan expresses it. He is so used to me being so involved in my work, having lots to come home with and we talk about our various jobs and we know a lot about each others work, and we can ask each other what one thinks about this problem, and we are close enough to what goes on that we can comment knowledgeably. I think he wonders, "What are you going to do?" and I say, "What am I going to do!" I'm just hoping I can make it (laughs) through my first few months. He literally sees me being bored, hard for me because of doing these other things, and "What are you going to do with your time?" and, as I said, I'm just bowled over, being overwhelmed with the looking after the baby, I have no problem about thinking about filling my time.

V: What do you mean when you say overwhelmed about looking after the baby?

C: Oh, I think I'm going to be tired, and I want to do a really good job, that I will be able to breast feed well for 8-9 months, or that I won't get too tired or too bogged down with a zillion diapers and maybe a crying baby and maybe all the million and millions of task involved with the young child and I can't, maybe because it is unknown, I don't know if my baby will be a "good" baby or one that is fussy, and will I be able to handle and know what the baby needs to deal with that, so that feels overwhelming to me. You see, work is manageable, you know what you can do there, you can have it organized, and you know that you have done 10 years of this and it all very manageable.

V: Do you think you are more of that "unmanageable-ness" of being a mother at home because of your experience with other women in this kind of a setting?

C: Yes, I think so, and I think I have pursued it with women too. At the time when I would talk to women about that—you see them coming in looking all harassed and you'd ask them about it -it was interesting to see them over time because that harassment went away, but they would talk about feeling so disorganized and say they "can't seem to get myself together," and would talk about going from being very organized, work oriented, career oriented, and then this little thing threw them for a loop. It would never be really horrible, horrible, what that "I didn't believe this could happen that I would feel this disorganized, that I could go through the day without having brushed my hair," so I am anticipating some kind of disorganization. Nathan sees it as how are going to hack this being at home.

V: Aren't you almost saying the same thing, not because you won't have enough to do but that you'll have too much, too overwhelmed?

C: Yes, and really sincerely doing a good job, knowing that there is so much to learn and so much to delight in. I hope I can get past the tiredness and feeling disorganized and frustrated, and really enjoy that part of it. I think it will be fine. I just have to trust in myself, and then I will call on people that can help to get it all together. My Mom is coming out for a while.

V: Can you tell me about your relationship with your mother.

C: Really pretty good. She will be a good person to be with me because she is not one to say do it this way. She never imposes, says "I'm here to help out," and will take direction from me. And she still knows me well enough to be able to say "Now," (when I was home for my holidays this time, she said, "You can't be depressed about that, Christine, you get out of that bed"—she won't let me get overwhelmed either.

V: She will give you the care that you need at the time.

C: And she will be willing to mother, to be the mother of her child now trying to be the mother of her child. She will take that in stride and that way sees her role.

V: Have you talked to her about this?

C: No, that is the way my Mother is. I'm lucky, I feel a kinship with her that others don't seem to have, so I think it will go very smoothly. And if it doesn't I can say, "Mother, this is bothering me, so bung out" and she'll be able to handle it pretty well.

V: Is this her first grandchild?

C: No, it is ~~not,~~ but it is, hum—funny you should ask that because my brother has had two children, but Mother has found it really hard to be of assistance. She has felt very hesitant about helping or not helping, saying or not saying, with my sister-in-law. And my sister-in-law said to me, when I was there, "Your mother is acting as if it is her first grandchild," and not wanting for her to feel bad, I said, "I am her daughter, her only daughter, and maybe that is why it is different for her. Try to remember that". I think she has a different relationship with me, but is something to do with me being her daughter. It was, it was very exciting for my mother. I think it is because she and I are quite a bit alike. She was a teacher and didn't have her children right away. She was anticipating seeing how I was going to handle having a career and being very involved in my work, and seeing how that was going to mix with my life. My sister-in-law is very much a mother at home, and that is her life. My Mom is excited to see us take this on, being a very different couple. My mother is really wanting to come and help and it is hard for her to be this far away. I am hoping she will stay 3 weeks anyway, and I'd love to get my Dad out too, and I'm not sure he'll be able to come. He is looking after his mother and it is hard for them both to leave. I hope I can convince them. In the long run, I am very concerned about living so far away from grandparents because my experience with grandparents is really positive. They lived close to us, and I learned so much from my grandparents, and I've thought it would be too bad that my children would live so far away from both sets of grandparents. Nathan's parents live on the coast. So I'd love them both to come, even if the baby is quite young. I wish they would have such a good time with grandparents as I had.

V: Is there anything else about the experience so far that you could talk about?

C: Something has happened just lately, Vangie, about 2 weeks ago, that is a revelation to me. Up about 2 weeks ago I was feeling really physically there wasn't much that I couldn't still do, even though I was getting quite pregnant. I fill my days, really quite filled, and I work hard and try to do all the things and that is always the way I've been. I don't if it is just that I have to get through school and I have to get through work so I had better darn to be alright. About 2 weeks ago I had an appointment with my doctor and my blood pressure has fluctuated. I think it is because I go tearing over there, and go flying into the office, and the nurse takes it and it is higher than it should be. It is higher than I think it should be judging from—I get Alice to take it—and it 110-120 and I go to that office and its 140/. My doctor, he says he knows what I'm doing [too much]. He says, "Christine, you have got to think about what you are doing each day, and get enough rest." And he really sobered me. The fact that you blood pressure fluctuates like that is an orange flag to me, and makes me wonder what you are doing, and maybe it is a sign for the future. He did not alarm me, he just made me think, that I can't decide that I am just so tough that pregnancy is a breeze, or that I have to be well because I have so much to do. I walked out of there, and at that point the baby was breech—Breech!; that is not supposed to happen—and I walked out of there feeling, not depressed, but a lot about the running around, about the things I try to pack into in a day. I've got to slow.

V: You've changed?

C: Yes, I'm more conscious of the pace, how I go through the day. If I'm tired, well, you don't do the two other things planned. I do what I have to do but I don't do the extra. And I needed someone to just make me aware of that—pay attention to my body.

V: How did you feel when I said you looked tired?

C: I feel tired, I know I'm tired, and I wouldn't succumb, on the weekends I wouldn't nap, I don't need a nap. Now I nap on Saturday and Sunday. But I haven't felt badly, which is different from the women in the prenatal class who complain about this pain or that. But I am careful to exercise, not a fanatic, but I exercise. For the last year and a half I swim and that is so good. I swim 3 times a week, I go to a prenatal exercise for muscles toning, at the Y, attached to Jane Fonda—toning, stretch, and yoga, relaxation and toning that I think will pay off. And I've always eaten well, and have had no problems. Nathan said what good shape I'm in. So I've just whizzed through.

V: So, you said you have to listen to your body—there is something to the physical change that has to be addressed.

C: Yes, and certainly the fatigue, not boredom. This is real fatigue and you have to lie down, whereas before I was pregnant, I would shrug that off. You know, I get the funniest looks a the pool. I've wondered, they stare—I wear my Speedo— you get looked at.

V: Do you like it?

C: I like to think I look good. Women are always —with a smile on their faces. There is a change in my father. He is more old fashioned then I thought it would be. I shouldn't do anything. Had a close and warm relationship with my father. He is more protective in every sense. I think he sees me being at home, and now in pregnancy. Little things that he said. My younger brother has been the biggest shock for me. My younger brother is the one I am closest to and probably the most alike, and I've had to struggle with this one. He is married to Theresa who is a very traditional homeworker wife, and likes it, and enjoys it. So he has chosen to be married to someone like that, which was a little bit of a shock to me when that happened, and then we had discussions about what I hoped to do and he was not supportive, very negative, about me wanting to go back to work in a year. He said some very hurtful things to me, so that I finally had to tell him, "Tom, you are talking to your sister, you are talking to someone who is like you, put yourself in my place and someone told you that you had to do this, and you just tell me how you'd feel if someone told you you had to quit your job (he is a professional, and he likes his work), how would you like that?" and he couldn't hear me, and I talked to my mother about that. Maybe he doesn't feel comfortable about what his wife is doing. But I was shocked and quite hurt, and wanted him to be supportive. And I did mention the idea of Nathan taking some time off work and he thought that was a terrible idea. It closed a door that I thought was open. He couldn't talk about it very well. Maybe some other time. I still value what he says about me and I felt, probably defensive, but quite taken back by his attitude (further discussion about her brother and her older brother).

V: It will be interest to see how that relationship progresses.

C: The last thing on my list to tell you, and I've talked to my girlfriends about it, are the expectations of myself and Nathan's expectations of me to date and how I am worried about them changing. Always up until now I've had the feeling I could do anything I wanted to do, career wise and everything, and I hope it doesn't sound boastful, but it is where I get my confidence from. I was brought up to take what your skills are and you can do most things You sort out what you can't do—you can do most things. Nathan is like that to, "try a little harder and you can do most things." In fact, he has taught me, for example, some of the sports, but you deal with fear, and it is very satisfaction to get over fear, and that supports that you can do almost anything. So the two of us live a life expecting each other to overcome most adversaries. We haven't had big failures, or tragedies. I expect myself to carry out my job, run a household etc. etc. and Nathan expects me to do that too. Sometimes I feel like saying, "I'm tired, and I don't want to everything work, and go to school, AND have babies." What if I want to just have babies. No, that is not alright. I guess my fear is that I won't be able to say, "I can't do that".

V: And you say that this is something you've talked about with your friends but not so much with Nathan?

C: I've talked to Nathan about it, but Nathan still in, "Christine, you can do this, it is not all on your own, I'll help you, I will." And he always does. I say to him, "But Nathan, what if I can't do it. What if I want to do nothing except this" I feel that it would be a disappointment for him and it is equally a disappointment in myself. But Nathan says "Don't even think about it, you can do it." It is his attitude about labour and delivery too. He is not the least bit worried. He says,"Christine, you're body is in good shape, I know you have good endurance, and I know you good strength, so you will be fine". I will be fine. But Nathan, "I want you to know all about it so you can help me if I am not doing fine." "Yes, I will know all about it but you will do fine," and that is the attitude, to date, and it is a good attitude and probably has got us over the roughest parts of our relationship and our life. I will with effort.

V: Is it maybe feeling that just being pregnant and being a mother is a big job and maybe that is THE big job.

C: You can't reference in anything you have done so far, it is this big unknown, you don't know how it will be. Most other things you can reference somewhere.

V: Has that feeling come recently, as you are getting more tired or was it there at the beginning?

C: It was there at the beginning, and it is a combination of things too—taking on school at the same time. Sometimes I think I'm nuts. Very consciously, we thought it might not be a bad combination. And I want to do it and do it pretty badly. Maybe it is my need to not just do one thing but do 2 or more—not just work, not just have babies, not just go to school, but do a combination of things, and I guess the unknown of mothering that makes me worried that if I say I just can't do it all—and that I just want to be a mother I will feel badly and I will let myself down. It doesn't preoccupy me but it is on my mind.

V: You say that you talked about this with your friends, and do you get understanding from them?

C: I sure do. Usually they just relate work and mothering, but—one friend is expecting twins and she has had to rethink what she is going to do. I don't know what I can do. It is the most fearful thing for me is what Nathan might expect. I have always been a very equal kind of person with him, and have done many things. It never occurs to Nathan that I won't be able to do things with him, "you can and you do." I wonder what will change in me and what he will think about that because dependency is not something I want and I know Nathan would not want. It is because it is unknown and you have nothing to compare it to, nothing!

V: Have any of your friends had children?

C: Yes, one girl, it has been interesting to talk to her, a reporter, and that life, and it is neat to talk to her because she went through a very traumatic time to get adjusted but that is all worked out for her, part-time for a while and then went on full time. But it is, I don't know, Vangie, (voice very low) if I can't do it, is that alright? Jennipher talked about what women have accomplished over the years, she is very involved at looking at women's issues right now, and she said, "What is it about married women over the years, in 1920/30/40s, and it was single women who did things, what is it about mothering, never mind being married, about mothering that is it—that you are so divided in looking after and nurturing your children and other things you have to be interested—so that you don't have the time or the energy to do both things." She was just questioning, and she says to herself that, and I might too, what would it have been like if I hadn't even got married and had children? One of my staff members, right now, is struggling with (she is middle-aged, is very bright), is desirous of going back to school and carrying on. She feels that she has a good span of life ahead of her to accomplish things, and she gets very down—she has a fairly old fashioned husband, "Why would you want to do that dear?" and two older children, who in my view still act like children and a very demanding mother who lives with her. And I've talked to her—who has given everything I can give and I have nothing—and then I feel badly for her because she may never accomplish what she dreams of and what I think she could do given.

V: It is a dilemma. It seems like a good place to stop. What is it about pregnancy and how do we as women now in our present situation handle becoming mothers. How does pregnancy help to prepare us to do that? How we really come to grips with it. The fact that you can talk to your women friends is significant.

C: For sure it is. I feel fortunate to be able to talk to women here who have gone through the initial business with there children but who are still questioning and struggling with that, and with women who are in my exact same situation who made the decision to have babies. It is very important for me to do this. I can't tell you how important it is for me to do this, in that I think it will make a difference in my life, but you still have it in the back of your mind that question. You know there will be change and you can't anticipate making that change, whether it divergences your course in your life for ever, and that is not necessarily bad or good but just that men never have to truly have to deal with that, ever.

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C: It was really quite discouraging to go to the doctor on Wednesday and find the head was just as high as it had always been through my pregnancy. In retrospect now that was a problem that his head was high, but I thought, oh, gee, aren't I supposed to drop, and how come the head isn't lower, I don't feel like it is any lower, no pressure, no trouble sleeping through the night, no urgency, I wasn't uncomfortable at all. So I was quite discouraged on Thursday, one day late, (laughs)—feeling quite discouraged—and I went into the office and talked to Mary and Alice and was saying that I wasn't very tolerant of this and want to have the baby now, and it was good to there and I had some things to do, you know, I had to go to unemployment, the bank, and I knew this time I was quite mobile and able to get around. So, on the one hand, I was saying don't get discouraged, this is not a problem here, and then on the other hand this better happen soon, and then I was also worried, not worried, concerned, that my mother was coming on Saturday, and I thought, heavenly days, if I am two weeks late, my mother would be gone by the time the baby would be born, so I kept saying to myself that I have to have this baby, plus I had many, many phone calls, "Hi, Christine," (silence), and "Yes, I'm still here." So I was quite discouraged. Thursday night, was the first hint, but mostly Friday I started to lose my plug, and was quite sure, had lots of show, and I went to that workshop, and glad to be at the workshop, and that was really good. I was quite excited and I was talking to my staff around the same table,

V: Were you having contractions?

C: No, not a thing in the morning. I came home from the workshop at about 2 p.m. I didn't stay all day. I started having menstrual kind of cramps, very low in the pelvis but definitely all at the front, but nothing I couldn't handle just walking around. I could feel the tightening and the relaxation, and I said, "Don't get too excited about this, it could be false labour too." But happened all afternoon. I had a sleep in the afternoon, and I had to get to some last minute things at work, sorting out staffing. So I was talking to my boss, so I was on the phone for a good two hours in the afternoon, sorting out staff changes that she really wanted me to make a decision about (laughs), and my mind was very much on that, because they were major decisions, and major changes in the office, and I appreciated the opportunity to have some input into it. Then Nathan came home, and I just had cramps in the front. I had told him in the morning that I was having show and he was quite excited about that. He said, "Perfect timing, it's Friday, and I'm not going anywhere, and I'll be home, and just hang in until the hockey game is over." And I was glad because other days it would have been harder to make arrangements. So he came home and I had a light supper, just yogurt, which I love, and it tasted really good. And then I made Nachos later, and I did not feel hungry for them but Nathan thought that was great, and would eat them during the hockey. So I made them and was eating away, I really like Nachos, cheese, spices, and then at 9:30, I was thinking about my pains and noticed that that one was coming from the back. Up until then I told Nathan I wasn't in labour but now I thought I was. Nathan said "You should stop eating these" and I agreed. And then we started to time them, 7 min. 10 min. and then about 10:30 they went to about 4 min., lasting about 30 seconds, or 40 seconds, sometimes I didn't bother with the length, it wasn't hard for me. I thought that I might be going in at 2 or 3 in the morning, but not right now. (Starts to feed the baby)

V: He sure can latch on, can't he.

C: Strong, and active. I thought maybe at 2 or 3 in the morning I might having to go to the hospital. I still could walk around, and I didn't want to lie down, and I think you should to walk. I tried to encourage him to sleep. Then my contraction settled down to 4 min apart, the hospital had suggested that go in a 5 min. apart. The dog really knew that something was happening. I had lots of dark red show, quite bloody, which worried me some. I remember thinking this over. We took off in the car, and I was getting quite uncomfortable. We dropped off the dog, and arranged Pete to pick up my mother. Then we scooted off to the hospital. You know what struck me (talked hesitantly) when you go through admitting, you know I was pre-admitted, so that is not a problem, but they are so—Your name, number,—"Do you know I'm in labour", It was so routine for them, and I'm sure they all know you are in labour so—the admitting was quite long, and I was getting quite uncomfortable, and I needed to lie down or something, to get into a relaxing position, and so I needed to get up to the ward, to lie down and get relaxed, and them asking for my social insurance number, and I had forgotten it, and now what do I do.

V: Sorry lady, go home (laugh).

C: So I remember thinking that this must be very boring for them, these ladies coming in all in labour and all excited, and trying to get on with things, and this routine business. I sort of wanted to giggle, just like the movies, you are dying and they want to know your insurance number, so it didn't last long, heavenly days, it was only a matter of minutes, and someone came down from the ward with a wheel chair, but she did not use the wheel chair, and I expected to walk. Nathan had gone to park the car, and I wanted him to be there, the nurse would have been quite helpful but I wanted Nathan to be there, and he came roaring and caught up on the elevator. Then things happened really fast. They did a lot to me. I can't tell you a lot of the things that happened between arrival and getting into bed. Its vague, I'm sure that they took my blood pressure and those things, asked a bunch of questions, course Nathan could to answer quite a few of them. But I was really intent, I wanted to lie down, wanted to get into bed and to get relaxed. That happened quickly but there seem to be a lot of activity. The nurses introduced themselves and told me who they were, but I can't tell you there names, but I can remember that this was nice a soothing, the room was dark, too warm, everything was too warm, the whole stay was too warm, just sweat to death. So I was just hot, hot, hot the whole time. It was a quiet room and I thought that that was fine, it was fine for me to be by myself with my husband or with them. I can remember getting the gown on, and there were several nurses involved and couldn't quite figure that out, didn't seem that there was just one with me, mind you—there were at least three faces I remember, different nurses who were with me, examining me or just helping me, watching the monitor, or

V: You were on the monitor then?

C: They put me, not right away, but after they got me comfortable, Dr. Henry was on the floor. I heard his voice right away, and I guess he had had another baby, and that was very comfortable, and he came in, and asked me how far apart, and I said 4 min. and asked how strong, and I felt a little funny at that point because I felt overwhelmed with these first contractions, the early ones. I remember saying to him that they felt strong but they were not as strong as they got, that's for sure. But everyone was so tender, their touch so tender on my abdomen. I expected them to press harder and they didn't, they were very light fingered.

V: That wasn't painful then?

C: No. I was surprised they were so light on my abdomen, the nurses and Dr. Henry, and he gave me an internal which was fine, quite comfortable and said "You are 3 cm". 3 Centimeters. I was just so discouraged. Oh, this is not enough, I should be six! I thought, not out loud, to myself, "I should still be at home, I shouldn't be here." Yet in the same thought, I was glad to be there, because I felt overwhelmed by the first contractions. "This is contractions! Am I going to be able to do this. This feels hard."

V: Did they start out hard?

C: You know I don't remember them when they did get worse, but I can't tell you if is because I know that now I could cope or in fact they did not get a lot stronger, or feel a lot different. They certainly did not feel a lot different to me all the way through.

V: They started, in your mind, quite hard.

C: It was at first. I had this contraction and, holy smokes, what am I going to do with it. And this is just the beginning, what is it going to be like in the end! I can remember thinking that over and over again. And after Dr. Henry examined me, he said, "Christine, settle in, it could be a long labour." he said that once, and I said, "Yes, I know, I expect to be all night with this." Then he left, and the nurses were just with from then on. They gave me an enema, and I was glad of, and yes, but I had just ate Nachos, and had supper, and they thought it would be productive. And I felt cleaned out.

V: Was that difficult, and did you get up to go to the bathroom?

C: No, I got up and was sitting on the toilet and managed a contraction. I was able to cope, I was alone, and wanted to get back up on the bed. Then they put the external monitor on me and I felt, you know, I thought it would be restricting, I did whatever I wanted, I rolled over, the nurses were terrific about that, they told me to move and do what you have to do, and we will work with this and if it gets off, or gets out of place, don't you worry about that, we will deal with that, so I didn't give it another thought. In retrospect, I was really glad to have had the monitor in the end, and I think it was helpful for Nathan, he immediately knew all about it, what all the readouts were, he would ask a lot of questions, and he knew what everything was, and that was really good for him because he then felt more involved, and helpful in being able to work with me in the contractions.

V: Was the monitor right beside the bed?

C: Yes, if I had opened my eyes I could have looked at it. I could hear the heart beat, and I remember asking Nathan what was going on, and he would say that the high so far is this and it goes down to this level. The nurses were good in saying this is normal when the heart beat goes down, and they talked to him about the range of intensity of a contraction, and how he could read that, and of course he told him what the range of contractions were, and he could see then that was really hard and then he could say it looked like this, the peak and it was probably a good strong one, because of what the nurse had told him. It was helpful information because I could say that was a strong one and I made it. I was able to do that one, it was helpful for Nathan to feed that information to me. And he was quite interested to know about that too.

V: What did you do during the contraction?

C: I found I had basically two types, one that would build very quickly and peaked almost immediately, and I could tell if I was going to have one. On the first sign, "Oh, its going to be another one of those, and I'd knew it." The others would build much slower and be longer, but they would not be as nearly as intense and I could tell you when I was going to have one of them too. And I usually had one of these peak ones, and 2 or 3 longer ones. So I knew I did not have to deal with these peak ones every time. At least the pattern seemed to be like that. What I did, and I must have been in transition, I just used chest breathing the whole time, and maybe used abdominal breathing at home, but wasn't very aware of that, and I never did use a high breathing. I can remember not wanting to use my abdominal breathing because I did not want to put anymore pressure on my abdomen. But I found it really helpful to take deep breaths in and out and really concentrate on that. But one of the most important things was Nathan put his heel of his hand into my back and really pushed. At first he was light, and I said really push, really push! Of course, he practically moved the bed, then he had to find out where the breaks were and was trying to figure that out, because I needed him to put the full force of his arm on my back, and it really took the edge off the contraction. It was hard on him. I could snooze between the contractions and I really did once I got rid of the shakes. The first hour or two that I was there I just shook and shook and shook between every contraction. Nathan asked me if I was cold, but no, I was boiling, and thought that this was just normal, and the nurse said, yes, it was normal and that I was in good productive labour, and I couldn't stop shaking. But the hard thing was that I couldn't relax, just shake, and not relax between the contractions. That finally went and I really even dozed between contractions.

V: What was going on around, were you aware of the people?

C: Two or three nurses, I'm sure it was three, and they would come and go. Nathan was—there were times we were alone for long periods of time. When I was throwing up, which I did three times (Nachos, yuck), the nurse was right there and she gave basin to Nathan, and she emptied them, and when I did it again Nathan knew what to do and called the nurse. They were getting worried about my hydration and gave me ice chips. I didn't feel that I was really thirsty but that made sense. Nathan kept giving me ice chips and kept giving me five in my month (laughs) and I had to tell him to just give me one at a time. He wanted me to take a whole lot. When I had a contraction I could not have a mouthful, and I can remember that he tried to give me more than one.

V: Were they giving you water too?

C: That came later, but right then I was only given ice chips.

V: Would you liked to have had something else?

C: Something different than water because I through up the water. It is not ice chips, and I did because I had to drink and not because I wanted it. I'm sure Nathan was concerned that these people who were whispering and talking were concerned about my hydration and Nathan got worried about that, and that is why he was so concerned about getting the ice chips in. I was getting irritated and I didn't want to be irritated, and I think he just listened when I said "Just give me one."

V: During your contraction did you make any noise?

C: I think I did but I must have been in transition I can remember saying to Nathan, when I knew it was going to be a hard one, I can remember feeling uncooperative, and saying, "I can't do it, I can't do this Nathan" and I'd say that to him more than once, and I don't want to do this, "I don't want to do this" and he would say, "Breathe, Breathe," and put his hand in my back and be close to me, and he would say various things that I was doing all right, and I can remember complaining and I didn't want to cooperate.

V: When do you think you were in transition?

C: I don't know. The only time I can put it into time frame is when Dr. Henry came in at 5. I had no sense that this must be it. He examined me again at 3 or so and I wasn't even 5 cm.

V: That is not so bad you know!

C: Vangie, I know, but I was supposed to be at 6 you know. I had gotten myself all "hepped" up for transition, and I was supposed to be there and that is what I had to really get through. None of this fooling around till 7—that was the easy part. Then he examined me again and the next little while went quickly and I know I was in transition then although I didn't recognize it because I had vomited consistently throughout so I had nothing to judge it by.

V: Were you shaking then?

C: No, I was shaking at 3 cm. and the shaking never came back and I felt quite relaxed between contractions and I can remember that hours went by and feeling less and less like cooperating. When he came in at 5, the nurses were very good. I didn't talk to them, I'd talk to Nathan. I'd tell him that I didn't want to do this, and, "Oh, Nathan, I don't want to do this", and he would say something to them. What happened at 5. Dr. Henry came in again so was quite surprised that I was almost 10 cm dilated and, oh, where was transition? I can remember thinking that was alright, I had one of those strong, peaked ones, then I had a couple that were longer and I just seemed to be able to able to cope with them and then they seemed easy compared to the peaked one, and then when the peaked one came, I would get through it knowing that the next one wouldn't be like this. So I was quite surprised that I was almost dilated, but then that was the first time that I felt worried at all because he said, "There is just a lip left she should be wanting to push," and he said, "Christine, do you want to push?" I said, "No, I do not feel anything, not any desire". He said that he wanted to examine me and look at this little lip. It was awfully uncomfortable on my back and he, I guess he was manually trying to manipulate that and that hurt terribly, I feel like it burned, and I don't know whether that was true—a different pain.

V: Was that harder to handle?

C: Yes, I couldn't relax, I stopped breathing, I'm sure, and Nathan was telling me to breath and I stopped and tightened up. I can remember saying, "Oh, don't. Stop." Saying stop and Dr. Henry was saying, "I know, that hurts doesn't it," his voice was very soothing and he always touched my leg to let me know that "yes it hurts, but." He talked to me during that, and didn't do it very long, it was only a matter of minutes each time, but then he said to push.

V: Were you up any of this time? Did you go to the bathroom? Did you get out of bed?

C: No. I switched from side to side, I'd roll over. The only time I was on my back was during an examination. I must of looked relaxed, and I had my legs up and was really quite loose, and Nathan would roll me over each time. Then they got me to push, on my back, and I didn't feel anything. One thing that was helpful was that when I was pushing the contractions felt better, don't know why, except that it was down ward pressure on my abdomen, but it felt better. So I pushed and pushed, and Dr. Henry came in again, and I remember the second time he came I remember thinking he is going to do that again. He must have seen my face because he said, "I know, I'm the big meany," or something like that.

V: How far apart was that?

C: I really don't know, it wasn't that long, maybe 20 minutes.

V: So he had let you push for 20 minutes to see what that did?

C: Yes, to see if that had done it. The sound of his voice, the first I had heard him so anxious.

V: Was the monitor on then? Was it something in the monitor he was anxious about?

C: As far as I know, not, the baby's heart rate was fine and my contractions were still the same. But he thought that I should have been pushing or wanted to push. But I had no desire to push and I think that concerned him.

V: Did it worry you too?

C: Yes, I said I wonder why not, and he said there was a little lip left and so I said that was why. So I wasn't terribly worried then. Then he came in the second time and he said he would put me in the birthing chair to see if gravity would help. That was fine. So they wheeled me into the chair, Nathan helped me,and that was not uncomfortable. And this one nurse helped me to push the whole time I was in the chair.

V: What was the chair like?

C: It felt quite comfortable for me, I think the height is just about right. If you are really huge woman or a really tiny woman person it is almost impossible. It is quite cold, they can't put anything behind you to make you feel warm.

V: It is plastic, isn't it?

C: Yes, so you are sitting on the plastic. That part didn't feel comfortable, the chair didn't feel good at all. But certainly to push like that felt alright, and I pushed and pushed. That was the first time I felt that I must be doing something wrong, not pushing right. The nurse would say, "Now, push to your bum, push to your bottom." and Nathan could see when you did it right. He said, "Once you got it right, you did it every time." But I thought I mustn't be doing it right. The nurse was very, very encouraging. She would say, "That is good, that's good," and I felt that she was being very encouraging. Only to find out later, that every time I pushed she look, and she's shake her head like that. Nathan saw that but I didn't. And then I would feel fine and then Dr. Henry would come and say, "Christine, you are still essentially the same as I left you an hour ago." What? I thought I was doing all this and nothing had happened?

V: The contractions were manageable then? or what was happening?

C: I was getting to the point where I didn't know I was having a contraction.

V: And the monitor was still on?

C: Yes, it was internally now, and I literally could not tell you if this was just my muscles aching from pushing or this was a contraction. And I said to Nathan, " You'll have to tell me, I want to know when it is coming, I can't feel it when it starts," probably if I hadn't been pushing I would have felt it as it peaks. But I couldn't tell you when it was first beginning so that I could take my deep breath to get into my push. Nathan would tell me when it was coming and I would take one or two deep breaths, but I literally could not tell you when it was coming and never a desire to push. So the nurse and Nathan helped me with that and Dr. Henry came in and each time he tried something different. He said I was the same and said he was going to put me on a drip to try to make the contractions more effectual, and I remember saying that is fine, and thinking "Oh, my god," (laughs), that is awful because I was thinking of induction and how hard the contractions can be, and feeling that I was alright up till now as far as to cope with the pain but I wondered if I would be able to handle it when the contractions are supposed to be so much stronger. They got me all rigged up for that, and put me on the delivery table. So I got out of the chair on to the table and had an IV in and I was still pushing but not every contraction. I just said "I can't," and the nurse said that was alright. Nathan said that I should push "Try and push, Christine" and I remember the nurse saying, "No, it is okay, she doesn't have to, give her a rest," and that was good. It just feels like one big pain now, but it is not an unmanageable pain, but just a chronic one.

V: What was your perception of the room, were you aware of people, or what was your focus?

C: Into myself, my body and what I was doing and I can't remember seeing peoples faces very well. I can remember feeling Nathan and hearing his voice and remember holding me, grabbing my shoulders, helping me up, or taking my arm, but I can't remember looking into his face, I can remember which nurse was helping me push because she was down in my vision, but I can't remember anybody else coming or going but there must have been people at this point because the delivery room was getting set up. But I can't remember any of that. I was thinking about me and the pain and pushing, am I pushing right?

V: Were you thinking about the baby?

C: I didn't think a lot about the baby, and the reason I didn't was because I could hear his heart beat. I could hear his heart thumping all the time and it was fine. I could hear it slow down during the contraction when I was pushing.

V: What was the experience like of hearing it somewhere else and knowing it was inside? I'm curious about that. Because when you said it you motioned that you could hear the heart beat.

C: That is where it was, over there! That is where the noise, where his heart was, (laughs) There! I could hear it all the time and remember pushing four times and hearing the heart beat slow and relaxing and hearing it speed up. But I don't, no I never, I don't remember even touching my abdomen, or feeling like I needed to do that, and I thought I would because I found that during my pregnancy I found it very relaxing.

V: Where was the focus of Nathan, was he on the monitor?

C: He was very much on the monitor.

V: And what about the nurses?

C: I think they were, the one especially was really looking at how I was progressing and she was trying to be extremely encouraging and she was—I felt her support all the time, she was trying to make me feel alright. Nathan would say "Now push one more time" and she would say, "No, let her stop".

V: She was the one who was looking at you? You caught her eye and would look at your face?

C: Yes, and she would look up at me and say, "No, it's fine." I can see a little bit more of the hair, and that just kept me, meant I could do the next one!

V: I am just curious about one other thing. Was there any sort of sense in anybody that said, open, release, those kinds of words, or did you think about them? Or how was your body feeling, was it feeling open, or was it feeling tight?

C: Tight, closed, terribly tight. Very, I tried to -- when I had a really productive push, if I had been any other woman (laughs), I could feel, the perineum, I could feel it good out, I could feel myself making things bulge, or imagine that happening, that is a good push, I could feel that, and Nathan said afterwards, you could see it bulge, you could see when you had done it right. But the nurse never said that to me and I did not feel very open, I felt tight and that nothing was coming to the bottom, nothing was coming to where it should be, so I never feeling that way, and by this time I guess it was 6 or 7 or 8 and I could feel my energy going.

V: Were you given anything?

C: Ice chips and water, and that was better. Nathan would give me a drink every time and that was better. I did not urinate, did not feel like that. I was very hot. Nathan had a cloth on me all the time. Nathan was very hot too, and he was very hot. The cloth got so warm, and the nurse would take it and get it cooled off and I was sweating, even with this little top, oh, I just felt drenched and I felt terribly warm. I can't remember that it was too bright, or too dark or too anything. Nathan commented later that he thought it was too bright, lights too bright for a baby, and I had no idea of bright or dark or anything. Dr. Henry put that drip on and nothing changed for me. I was quite surprised that this doesn't feel any different than it did before. When he was out of the room again the nurses were helping me push again and they didn't let me go very long with the drip. In fact, Dr. Henry, at this point was getting ready for delivery because I can remember him coming in and out in various green. He was getting more green (laughs) each time he came in and but it was the nurse still who was monitoring me, she was helping me.

V: Was there the monitor at this time too?

C: Yes, Nathan, he didn't tell me at the time, but later, that as far as he could see my contractions didn't change at all, they might have gotten a little closer together, but essentially they did not change. They took the drip off, and Dr. Henry again came in again and said, "You have essentially not moved" and each time I figured it had done something. I missed something, he moved the lip sometime in between the drug, he manually took the lip of the cervix and moved it over the head. He moved something because it was that horrible pain again. I can remember asking if the lip was gone and the nurse said that yes Dr. Henry did that. But it hadn't gone on its own. It had not gone on its own. Then he all green and he came to my side and said, "Christine, I have to do one of two things, forceps and if that doesn't work, you will have to have a section," and I knew that. And at that point I said, "Yes, I know", and he said he was going to try the forceps first. And I didn't feel bad at all, I didn't say anything but I knew he was making a good decision, so that didn't bother me. I was glad he was going to try the forceps first—I wasn't really keen on having a Cesarean— you know why—it is not anything to do with the Cesarean but that it would probably be another hour. It was the time and procedures to prepare.

V: You were ready.

C: Yes, I didn't want to wait any longer but I remember looking at Nathan who by this time was gowned, I said, "If I have a section you stay with the baby, don't leave the baby, you stay with the baby," and I can remember him saying, "I will, I will". I must have said it 10 times. I said I want you to hold the baby, o.k. And then I settled down again and I don't remember looking at him again. Then they had (Christine gave her baby to her mother) then things got really busy, seems to me there were three nurses, and there was another doctor assisting with the birth, and Dr. Henry gave me a pudendal block, and I remember knowing what that was, seeing a picture in the textbook, and that was alright. I was in the stirrups and they had put the green things on, before that I had this little thing on, and very busy, and everyone was draping me with stuff. And then, thinking about the pudendal block and the nerves it hit and it hurt a bit, not really bad, very quickly. And then gave me a local down towards my anus, and that really hurt, hurts more than anything. and then I was still wasn't looking at anyone, not looking at Dr. Henry, not seeing the forceps, I know I had my eyes open but I don't remember seeing anyone and he said, "The next contraction I want you to push, I have the forceps on, and I want you to push." I didn't feel him put them on, didn't feel a thing when they were applied. Then Nathan told me and the nurse said at the same time that there was a contraction and I started to push and that was the worst thing I have ever felt in my entire life (laughs). I just felt that everything was being just pulled, yanked, the pain was so excruciating, I stopped pushing and I think everybody. Dr. Henry said, "Christine, push," and I can remember him being louder than I have ever heard him and Nathan said, "Push now!" and what happened was that everything stopping because I stopped pushing. My legs went straight out and my hip, and I think I bonked the resident with my foot,- my feet went out and I yelled and yelled and said, "I can't push, it hurts," but I was yelling and but then I must have pushed a little bit more and then Dr. Henry said, to push the baby out on your own. He had taken the forceps off and the baby was born. There was one bid push then and then the baby was born. But Nathan said and I didn't see any of this, that when the baby's head was out the doctors eyes just bugged out, maybe the head was a lot bigger than expected, and that was when I ripped and tore. Nathan said there was blood all over the place, they were all spattered, had blood over their front. Nathan said there was blood spurting but they were quite splattered. I did not see that until after, and didn't strike me as being anything even when I saw that. I was moving my foot up and down on something and when I got my consciousness back and found I was rubbing against him (the resident), cause I thought about what I was doing with my foot, and what am I rubbing against (laughs), and I'm sure I hit him with my feet. Dr. Henry said something to me before he told me to push, not sure what, but I did not want to push, I wanted to pull back this hurt. But once the baby's head was down I remember having one great big push and he was born. And he came right up here and it felt so good, to have the baby out, good, no more pressure, not empty in the bad sense. Oh the baby is born and that feels so good, feel how that feels not having the baby in there anymore and the baby was put right on my stomach and he was very slimy and quite blue but I could hear him cry and that was fun and I didn't ask if he was alright then. They brought him up and I looked at him, and Nathan was saying it was a baby boy. And he went, they took David off, I put my hands down and felt his arms, I couldn't see him very well, I couldn't roll up and take him, couldn't do that, or feel that I needed to do that, but I touched him and he was quite slimy but that he was crying, blue, and then they took him away and were, of course, looking at his Apgar and checking him and Nathan went over to the baby and spent the time looking at him and that is when Nathan saw all the forceps marks and this little funny mark around his neck and he keep saying, "Oh, look at this mark and that mark," and Nathan seemed quite worried about that, and he watched all the stuff that was going on and I could just hear that, not see anything. I just heard the baby cry and heard Nathan talking to the baby and talking about the baby. Then Dr. Henry groaned, he actually groaned and he said, "Oh Christine" and I moved my head around, and I can't remember focussing on anything all this time, just hearing things, I remember the look on his face and hearing him, that something was distressing him and he said, then his voice got more like Dr. Henry, and said, "I want you to breath the nitrous oxide" and the nurse was beside me and I don't remember her face, but that part was handled well, sometimes the mask makes you feel claustrophobic, but I felt fine and I took some deep breaths and it didn't make any difference, it was just like breathing air, I know now he was manually removing my placenta and that was awfully uncomfortable, it hurt a lot, and it was only a matter of a few seconds and that was done. But I don't know what had happened. Nathan and I knew that he was doing something with my placenta and that hurt, but was over. Nathan came over for that to help me breath. They turned their backs and started to whisper, and I thought they were just trying to see the placenta was intact and that everything had been removed. It is an advantage hearing Nathan's side of the story, it is so different than mine because that didn't really worry me, and the forceps marks—they brought the baby over then and put him in my arms—and it was quite obviously a forceps mark—and Dr. Henry had said that he has a forceps mark, and I had seen them on babies and that didn't worry me, but Nathan was worried about that mark around his neck. He would carry David around the room and say, "You got battered up there didn't you David?" Dr. Henry was concerned about the mark on the neck and said he hadn't seen it and didn't know what it was—looked quite red and raw. I looked at it and guess and the baby did not seem very stressed, and I wasn't worried. Dr. Henry said he would have someone see him in the morning. And that was fine but Nathan was worried about what had happened to his neck. He was concerned about that and then Dr. Henry came over and shook his head, he had stitched me up while we were looking at David—(Nathan was calling our baby Conrad, he called the baby Conrad for five minutes, that was our fun name for him. He was continuing to call him Conrad. Nathan came over and asked me what we should call him. I said for him to decide, and he went and sat on a stool and after awhile came back and said, "I asked him and it's going to be David". Then he could call him David. He would call him Conrad during pregnancy and was still calling him that while he was soothing him.

V: You must have been feeling pretty good then if you were able to discuss that with Nathan.

C: Yes, if fact Dr. Henry mentioned that I had really perked up and I said, "Yes, I feel fine now." And that was after he had stitched me up and I had held David for a while and then Nathan had the baby back. The nurse was going to put drops in his eyes and then Dr. Henry asked them not to put the silver nitrate in his eyes right away, rather later. "That is one thing I can do you, Christine." And I laughed. They finished with a zillion stitches I'm sure. and then he came to my side and said, "Boy, I don't want you to do that to me again," that is what he said to me and he held my hand and I said I was just glad it was you who was here, and he went over and shook Nathan's hand and then he left. Then the nurses, I think three nurses were around, at this point, who finished with me and the baby. They took me off the delivery table quickly and put me on to the stretcher and made me comfortable and put pillows around me and gave the baby back to me and they left us, and they were tidying up the room, so they left us just ourselves there, and I breast fed David and that was so neat he just latched on, and sucked away and was not crying anymore and his little eyes were open and Nathan thought that was quite marvelous, and he took pictures of the baby, and then this really nice blonde nurse said, "Would you like me to take a picture of the three of you?" and I thought that was so cute of her. She really was very supportive of us, and she took a picture of us. They left us alone and I could talk to Nathan. I didn't feel any worse for the wear, and maybe I just didn't know. I knew that several things had happened, but it hadn't hit me. I knew that I had had pain and I knew that the forceps hurt me but I didn't know that I had that huge episiotomy and lost all this blood or that I had tore.

V: Did you tear inside?

C: I had a 4th degree tear and I didn't know those things just yet and all these people around me knew, and "You poor lady," and I was, "Oh yea, I feel fine." I felt so exhilarated that the baby was fine, and so responsive, and immediately responsive to me and Nathan, and how nice that was, and that this is all that really matters, that the baby is fine, and look at all he can do right away. See how much he knows, all the things he can do so quickly, only a few minutes old. How they can be comforted by your body and how can be comforted by food and sucking and being close and warm. And I settled right down and comfortable with us, and that made me feel so good. Then Nathan had him for a lot, for the first 20 minutes while Nathan had him while I was being stitched up and pulled out and everything else done. And Nathan was able to hold him, and soothe him so naturally, you never know how your husband will be. The nurses were just so helpful, and you didn't feel awkward holding the baby and I could feel her arm around me.

V: Did that supportiveness last the whole time you were in hospital?

C: Well, (hesitates) on and off, I was more conscious of it in labour and delivery than in post-partum. I was really impressed with them, how good they were, they were very conscious of saying the right things, being supportive to you, and watching your fatigue. Nathan was more demanding—you should be pushing—I'm here to make you breathe—and I'm going to get you to breath—to get you to push—and to help you with that—and your dehydrated so you better eat these ice chips. They were more—give her a break—she can rest now. But Nathan didn't know and he was trying to make sure that the baby was born alright too. Afterwards he was, angry is not the right word, but how do you ever anticipate this, the movies you show are unrealistic. I said to him that this does not happen to most people.

V: But maybe there is some truth in what he is saying. Maybe it is really hard to really prepare. How do you really prepare for the real situation?

C: I said to Nathan that he wasn't unprepared. I said, "You knew what to do, and you did all the right things. There isn't anything that you could have done differently." But I think it was after that he felt that it was a bad experience for me or someone. But that was initially how he felt. And he said that on the evaluation for prenatal he must say something about that. "If I had been a queasy guy I would have been on the floor long ago. It is just likely that I've been on vet rounds, seen lots of blood and deliveries." I think it was quite traumatic for him to watch and he did say that much to Dr. Henry credit he didn't make me leave or any of it and he probably could have.

V: But he saw he could handle it too.

C: He was glad that Dr. Henry did not ask him to leave and I'm sure he could at any point. But Nathan at the end, that was the only time the nurses and Dr. Henry asked if Nathan was o.k., and he said, "I think I'm O.k., I'm just tired and I'm very hot." That was the first time he had said he was very hot, whereas I had continually complained about being hot.

V: I wonder why it is so hot.

C: On the tour it was a 109 degrees too. It just felt terribly hot. Nathan was hungry too.

V: Were you hungry?

C: No. But Nathan was. They took the baby away and we had about 1 and half hours. Then they gave me a bath, and then they took me upstairs. My hearing was now more acute but my vision was blurred. And I got a private room and that was good.

October 5, 1985

C: I won't cut back on things that I think are important for my son and myself, continuing to breast feed and continuing to spend time with him and that is really important to me. I have 9 months maternity leave which will be up in February, and then you have 15 months educational leave, which I have been granted. My hidden agenda is, which I haven't told anybody about, is to have another baby in all this. I'm planning it in between terms next year. When I think about it I think, "You must be nuts." But I don't want to wait an awful long time because I don't want to have kids when I am over 35. I know that there is nothing magical about 35 but I just would rather have my children before and take away a whole bunch of worries that would go through my mind. So I would be doing it anyway. We hope to have the children quite close. Maybe that is all coloured by the fact that I have had a good baby who naps around 10 and nap for an hour and half in the morning and has another nap in the afternoon for a couple of hours, 2-4, and then he goes to bed about 7:30 and sleeps until 7. I can right now depend on it, that will be in any given day these many hours to do things. I am very narrow minded, I just do and do school. I look after my kid and my family, and do school, and that is it. Really boring. From someone else's point of view they see as not taking a lot of time out to do nothing, to socialize or watch TV. It is minimal. That suits me right now. When we are working together we are quite content to be with ourselves and David. That makes us happy. Right now. The need to be out doing other things is not high. I can see the advantages of having the children further apart but I feel, intellectually, that I can cope. I will probably coerce my mother for at least a month when the second one is born.

V: Having her was good for you.

C: Yea, and I know that she would be just excellent for have for that time. And I might have to consider for a few months once my mother is gone to have someone in to help out—for, say, 3 out of the 5 days, so that I am getting rest and trying to cope with school, and the children. I just might do that in the short run to help me through. Depending. I feel that I have options.

V: You know what to expect. It sounds as if you are careful with yourself, which is good.

C: So many of my friends say and my doctor said, and—I guess I was always viewed as doing to much, and I think that people have to get me into perspective, that I am at my best when I have just a little bit too much to do. I'm amazed how organized I can be. I can't believe how organized I get.

V: Interesting that you found that. One of the things you said earlier on was that why you missed work was that you had control of the situation. And at least when he was littler you had to go with the flow. Has that changed?

C: Yes, it has. Certainly, you can't—he will do what he has to do and there nothing I can do about that, but I find (interruption with baby and telephone)—you work with the flow (laugh). I feel that have a little more control of my life. And I still have yet had to very much to go with David. I am a chronic list maker—an A list or a B list—the A list must get done and if the B list gets done that is great and if not no panic. So I divide my activities like that over a week and I know and I take advantage of the three hour nap as opposed to the two hour nap. So organized in that way that I have. When he is asleep I know what I have to do, and I can work through them as his time allows me. When he is awake I find that I have to drop things and stop things just like that. I was thinking, "How is this going to work?" If I am reading something, wouldn't I lose the sense of it. Well, I might have to go back a page but I seem to be able to cope with that.

V: Do you find that you think about your reading while you are with David?

C: No, you know when I think about it, which is disturbing to me, is that I think about it at night. Last night—I have never in my whole life ever had any trouble sleeping—the night he was born I slept like a log. I just sleep really well. Well, I have had more nights with this one course particularly, when all I can think about is the jargon, in organizational theory. I can hear these words that are going through my mind. I am obviously thinking of the chapter that I just read. I said that I am going to have to do something about this. Nathan said, "Christine, are you sure that you are not overdoing it?"—which is just my style that I will just get in one more thing today. I am tired but I can do it until 10 and then go to bed. It is not when I am with him, and in fact, he can distract me from work. You know, I am really pleased about the combination. I have talked to people and am learning more and more about myself, which is very interesting and the neat thing about being alive. The first week that I went to school was the first time that he had ever been to anyone that long. I took him to someone that I didn't know very well. I felt very confident leaving him, and maybe that is was the difference. She is an older woman with lots of kids and obviously is very comfortable with children. I came back from those days at school, having had a really exhilarating day at school, and I felt so much more refreshed when I came home, and I felt okay on those days and seemed to have more energy for him then on those days when I was with him all day [nursing the baby]. As he has become routinized it is better but you certainly fall into his pattern rather than yours. But I do get very organized and feel that I have some control over things.

V: What if things don't go well?

C: If things don't go? Well, that is okay with me. My husband said the other day, he is really busy at work. He came home and was very tired. He said, "If only I was as organized like you?" And said, "What do you mean?" Nathan is a very organized guy. He said that I am always in crisis mode—that is the way I work. You work bit by bit. It is true. At the very beginning of school I preread my course, I had all my books read, for the one course, and that helped tremendously. It takes a lot of discipline because you are doing it in the summer and you are doing it when you don't have to, but I know that it will make a difference in September. So that is the kind of thing I do and I have a paper—well, you start that in September, you don't do that in December.

V: Where did you learn this? (laugh)

C: I have always been this way, always, and I don't know where I picked up the habit.

V: Looking at yourself before and now, that hasn't changed.

C: No, it's gotten better because I have to be even more planned, and I try and look at anything that I have to do, try and hone it down to what must I do, and what would be nice to do. So that I can be clear on my A list, it reduces anxiety. It reduces the feeling that I am not doing anything, or that I am getting behind.

V: If it is better now, is it because you know that you have David to look after? Does that make a difference?

C: Yes it does. I am trying to balance to very important things. They are both very important to me which has become clearer and clearer. But I can't leave bits of David off my A list. That is just not an option. So the things that you can throw out or keep in, you get even better and better and better at. In my case the biggest element is school. Mind you, I don't have other pressures that I am sure others have. I am not a housekeeper, I could care less whether that.

V: How do you deal with that because it is something that we discussed before, and obviously your house is well kept.

C: Nathan and I share it, and it just done. I may, eventually, have a housekeeper. I'll see how next term is with the three courses. But I work with that, too, doing a bit at a time. I don't let things get super messy or we don't spend a lot of time in the dining room or the living room, so that doesn't get that dirty. I don't have to do it. I do it in pieces, if I have time on a day when David is up, and needs to be supervised, that is closer than not, and yet I can do other things, then I will do some housework. And that isn't my style, I rather just clean the house today, and that is it, but it seems to work. The kitchen gets much more cluttered than it ever had, and I find I have to do much more just to keep my sanity rather than wading through toys and food all over, with David tossing things. I find I have to do that more on a daily basis. It struck me the other day, that when I got home from school and Nathan had been in Halifax and came back late on Tuesday night, so he slept in on Wednesday and went to work later. So he took David to the baby sitter. When I came home from school, when I leave the house it is ready for me to come back at noon, and to dive into the next thing. Everything is in it's place ready for me to go. I came home and the lights were on, the bed wasn't made, and there was junk everywhere. "How could he do leave this place like this, including the David's bed wasn't ready to receive him." I do all those things before I leave so it is not a rush for me when I come home from school.

V: When you say you share house work, it means that you share the big jobs?

C: Oh, yes. No, not the little stuff. I have to remind Nathan about that. The things that bother me, I tell him. He loves popcorn, and makes popcorn with 10 bowls, etc, and he doesn't mind going downstairs, and watching TV or doing something with his bowl of popcorn and leaving it like that up here. And I can't stand that, and feel very mad because I don't eat the popcorn and he leaves the mess. He cleans it up but maybe not for a while. Or you forget the mess, and it gets late, and gee, let's go to bed. It is not a chauvinistic act. He will clean it up when it is pointed out. But it is like he is not even tuned into the way it is. It is not that it is so bad, but it is bad when you have a child and you are trying to do other things.... Someday when David isn't nursing anymore, and I am away for a day, it is experiential. To me you have to be with a child all day to know what it is that the bed is not made and you want to do something in the bedroom. You have to stop, do something with David, make the bed and then carry on. And Nathan just doesn't have any feel for that. He has no feel for those small things that make it difficult to go through your day. He has a hard time understanding.

V: So the sharing is a different kind of sharing?

C: I couldn't have any better cooperation as far as cleaning the house and vacuuming, doing what we used to do, in cleaning the house. Nathan is good with cleaning the whole house sometimes initiating things. And he will. He is quite conscious of that. Sometimes I initiate things. Last night he thought he was going to be late at work, given that we are going away this weekend, and he phoned me at 7 and said that he couldn't stay any longer and was coming home. He got home and had supper, and I wanted him to do the grocery shopping that was to have been done tomorrow. He said that he would do it if I made him, and I said, "I am making you." He was very tired and let me know that he was tired. But I had some school work so he did it. He knew about the grocery shopping but didn't instigate it. I wish you could see us through that kind of thing. I think I know what is going on, but because he knows I would fit it in, and that it wouldn't kill me, so I wonder if the tendency is, "Do I have to get up, or do I have to be a lot more dragged out before he would say that he will do that?" He knows I have lots of energy, and can organize my day. It is just a matter of giving me a little bit more relaxing time today.... I don't feel in charge of the house. I feel I can feel it under control. I don't see it as an enjoyable thing, the grocery shopping and the cleaning. I could live with a full time housekeeper. I could see myself liking that. Someone who would keep ~~my home liveable~~, because I do not like it. Nathan doesn't particularly like it either. And yet we enjoy a comfortable home and would be quite upset if things got out of whack as far as the level of cleanliness is concerned.

V: So you have worked out that to your satisfaction.

C: Yea, we had quite a discussion about this in August as to how we were going to manage the house and the grocery shopping. We decided to go for a month shopping once, to the super store, what a zoo, but Nathan went with me and he is not very tolerant of line ups. It was important that we do this and that he be there, and I was amazed how well he tolerated it. That was a good thing to do. He picked up things at the store on the way home. I did a master list, and xeroxed, and I had to do it because I plan the meals and I know what I have, and it makes the job faster than not. I just couldn't do it every week.... David is a very happy baby, and maybe he expected that he would be fussy because I had other interests, and he talked about my needs in a much more positive manner. I talked about my desire to go to school and I think that he is relating to it probably because of things that are going through his own mind and what is happening to him. He is frustrated and dissatisfied with his work and he is able to relate to needing satisfaction in your work to have your life feel complete. I said that now you know what I feel like. I need that in order to feel good.

V: So, being a mother to a baby is not enough?

C: Not for me. I should rephrase that. It makes me feel really good, but it's just not the whole picture. I have to have something else, and it has to be for me.

V: Your mother, was she a teacher?

C: She was a teacher, but she stayed at home when we were little. She did a lot of volunteer things, so she wasn't always at home, but she probably would have been called a full-time mother, but she was a very active community lady.

V: So she did both.

C: Yes. And my mother is very supportive of that. Another interesting thing, Vangie, that was good for me was that my father said, "Christine, I don't think you can be at home full time, can you?" Because my Dad, I thought, felt that way. I first became aware of it quite a few years ago with just things that he said. But he was quite emphatic about it. He sat in front of me and shook his head and said, "You just can't be at home, Christine. That couldn't be the only thing you could do." He came and visited on his own after my mother for a week and it was really nice to be able to talk with him about it. Those things are important to me—I'll do them anyway, but it's important to know that my parents are supportive of it. And my mother is very supportive....

V: One of the other things we talked about last time and I'd like to follow through with is your episiotomy and the whole sexual thing. Is that all sorted out? Are you comfortable?

C: I feel really good. I was actually talking to Nathan about this last night and asking him how he felt after this whole thing. Nathan's perception before the baby was born—as many of the men in his office—"Oh, it's never the same again."

V: Really?

C: Yeah, a lot of the guys said it was never the same. And I was asking Nathan if that was true, if sexually things were a lot different—not just the physical act but how often you have intercourse—do you have the same feeling of intimacy. And I feel very good about that and so does he, that we feel even better. Different, but it's better. We'll laugh if David happens to wake up or needs attention. And instead of getting frustrated or upset by that, we'll giggle about that. But it's because you focus on what your child needs and it's not what he's taking away from me. We can wait. He'll be fine in a while, and then we can resume. It's not a big imposition. We've been using a diaphragm, and that's worked out very well. Probably it wouldn't be my forever choice of birth control. I still think there's got to be something better than a pill .... But it's fine and we're both very comfortable with it. I phoned my doctor once because I think I had some irritation from the spermicidal jelly and I don't know whether that's a combination of breast feeding and the mucosa being fairly dry and the jelly being the irritant—but it doesn't irritate all the time, but it does feel quite burning. It's not enough to prevent me from using the birth control or seeking another method, because I see it as being short term, until I get another pregnancy. And then after that, Nathan will probably have a vasectomy, so that I won't have to do anything anymore.

V: You just want to have two?

C: Yes. Ask me when I have my second, but I think that will be fine for us.

V: The episiotomy—has it healed up?

C: Yes it has. I'd say it took five months for that skin to feel like it wasn't stretched and tight and it would burn and feel very tender when we would have intercourse.

V: Did it leave a scar? Or was it your worry?

C: I think it wasn't the worry after a while. I think it was truly that this feels like the skin is taking a while to heal. It's fine now, but my girlfriend who had an episiotomy is still having quite a bit of pain with it. And I told her to try and separate the dryness or the lack of lubrication and perhaps think about and make sure that you're doing all you can to enhance lubrication and then if you still have a lot of pain, then maybe you need to see your doctor again.

V: And it's about the same length of time as you?

C: Yes, a month later. But it took five months to feel good. And I don't know whether that was the episiotomy or the tear or the combination. It was sort of on my mind—it didn't interfere with our lovemaking. The relaxing part was that I could anticipate the first pain and then I relaxed. But I don't feel that pain anymore on initial penetration.

V: You said after that maybe you should explore yourself.

C: And see where it is. I looked at it and it was hard to see. It healed quite well at least on the outside, I don't see mammoth distortion of the genitalia, but it was at the lower end of the vagina and I think that's where I tore too. I think it was just too much trauma to one place and it took a while to heal.

V: One of the things you talked about in your last interview was you were going to ask your doctor about squatting versus—he said he didn't like the chair but he used the chair—and he said you should squat but you didn't squat.

C: I haven't had a chance to ask him. I'm looking forward to the second baby. I have this feeling that it will be interesting to see how the next baby is born or how I deal with that. I don't know how open he would be to let me do that. Certainly you cannot experiment with positions once you are in the case room—you are on that table. But I feel that if I was in the labour room, and things were progressing—if that baby was almost ready to be born, he would let me have a baby there.... One of the worries I have before the next baby is, what if it happens like that again?

What if I get to what I thought was a fairly good labour and he examines me and I'm nine and three quarters and I've got this lip on my cervix—am I going to have to do that again? What if it happens again? And I think that next time I'm pregnant, I can be more prepared if that happens. I can say now, if it gets to that, what are you going to do? Can I do some other positions? He might say that, given what happened the first time, he might opt for a section, and I can see him saying that with all kinds of justification. But I can also pose to him if we should have experimented with not sitting, because I believe he did a conservative approach—much more than other doctors might have done. Maybe I needed more instruction. Or next time, between the nurse and the doctor and my husband and me I could have positioned myself better in the bed to push, because I was still lying down, and maybe if I'd had more help getting into a true squat on the bed, that might have helped.

V: It's hard to really speculate.

C: I wish that I could be clear in my mind that every option had been tried.

V: Had you thought that before?

C: Not during that process, Vangie.

V: Not during it, but you've thought about it since?

C: Oh yes. I've thought how I could have laboured better. I felt alright during my labour, but maybe it would have been easier if I had done this or that. I don't feel too badly about that because I did fine—I feel quite good about my labour. But that doesn't mean that it could have been even easier. And I said that next time I'm just going to try several positions to see if there is even a better position for me to labour in. And because I know what a labour pain is now, I feel I'll have more options.

V: What you're doing now, it's very interesting. You're saying, "I'm going to do this." In a way there's a sense in the interview that they made the decisions about what you were going to do, and I hear some of the concerns that you raised with me very early on in your pregnancy. And you said that one of your concerns was that you were going to lose your autonomy.

C: My ability to decide what I want to do.

V: Yes, during labour and during birth. And I hear you talking that way again, but I didn't hear it so strongly.

C: Well, during my delivery, I felt that I must have been doing something wrong because I can't push this baby down. And I can remember feeling very discouraged about that. And Nathan was really helpful and the nurse was really helpful. She would reassure me that I was pushing productively. But then Dr. Henry would come in and say under his breath that things were essentially the way they were an hour ago. I felt like—what am I doing? Why can't I get this baby down?

V: You were doubting yourself?

C: Oh yes! If I only could push one more time, maybe that would make the difference. And I was so tired. I was losing energy, and I'd say, "Come on! Get your energy." And I wasn't very easy on myself to say this because I'd been pushing for x hours. And yet I'd do it and do it and nothing would happen. And I don't want that to happen again.

V: The first time you said, and you've said it since. He came in and said there was a lip. And yet you were almost ten centimeters, and it didn't seem that you were in that state for very long before he indicated something about. Now why was that so soon?

C: He examined me at five in the morning, and I guess the thing that alerted me—not that I panicked, but I realized that this wasn't the way it was supposed to be—is he said I was almost ten and then he said to the nurse that I should have been pushing by now. And I had absolutely no feeling of needing to push. And then he got me to push with him.

V: And what did it feel like?

C: I said to myself, "Holy smokes, I've been through transition and I didn't even know it." On the one had it was ten and I was over that, and then he got me to push. He examined me, and I think he was trying to see if he could get the cervix over his head, and that hurt—it really burned. And he got me to push with him and that was okay. He was with me for about twenty minutes or half an hour and then he said to the nurse to get me to push some more and then we'll try the chair—try gravity. And that's when I started feeling discouraged, that I mustn't be pushing right.

V: That it was something that you were doing wrong.

C: Yes. I wasn't pushing effectively at first. Because I talked to Nathan and he said, "You can see when you're pushing right. The perineum bulges out." And the nurse and Nathan and Dr. Henry helped too, and they all said, "Do you feel how that feels? That was a good push." And then I knew where to direct the force.

V: Did they ever put your hand down there so you could feel what you were supposed to do?

C: No.

V: One of the nurses said to push to your bum. Because that's really not where you're pushing to. It's not like a bowel movement.

C: ~~No. No one put~~ their hand so I could focus on that touch.

V: You did it in your mind?

C: Yeah. I could feel how the good ones different.

V: And all through this time that the baby's heartbeat was fine. There was no concern about the baby?

C: He was strong. And that was important to me, that I could do this forever as long as he was okay. But it was a discouraging time when I think about the next time. I think about being pregnant and that feels really good. And I feel quite excited about the labour in that I want to do this and that and try things. I feel like I'll be able to cope with that and maybe be even better because I know what the pain is now. And I get to the delivery and I break out in a cold sweat because I want to be able to push the baby down and feel like pushing, and have the baby born.

V: Well, he's right, if the baby's head was there, you'd feel it.

C: I can't remember, but once the forceps brought the baby down, which was just an excruciating few seconds, but it was almost like I felt the kid hit the perineum. And Dr. Henry said, "Okay, Christine, push the baby out". And I said, "There it is, there's the baby". And then I could push. I felt that. I could feel the baby between my legs. And I couldn't feel anything when the forceps were being applied. Dr. Henry told me to push and I felt like saying, "Forget it folks." I was so tense and trying to deal with the pain. ~~But I felt~~ the baby come down through the pelvis and then I could feel it—the only time. And then I pushed. But that's what I want next time—I want to be able to feel that pushing and I guess it makes me anxious about that—that it will happen again and the baby won't come down. I'll feel badly about that. And I felt good enough about the people who cared for me, it wasn't a negative experience, but it's just a personal thing. I would like to be able to do it. And if I get feeling helpless, then you get help.

V: You did feel helpless?

C: Yes.

V: You talked a lot about the help that you had. You didn't talk about your helplessness, you talked about your help, which is the other side.

C: Yes. And as I said, it's important to make it clear that it was good help, but you should be able to do it yourself.

V: As you know, there's always those things that we have no control over. C: And I'm not a hero about that. It's just that I hope the next time that I can feel the whole thing. Feel the baby, feel the pushing, feel it being productive, feel the baby there. And certainly my doctor's very positive about that, and then I have to be too. But right now if you asked me to fantasize about my next labour, I'd get tense. But I'd do everything again as opposed to someone deciding that I should have a section. I would rather go through the same scenario than have someone decide to have a section and not bother with any of this. I may need to have a section, but I would rather trial it through and go slow as long as the baby is alright, and not make a snap decision based on lack of information. But I'm quite surprised at myself because I can feel quite excited about it, knowing what it's like now.... They keep saying your second baby should always be your first so that you know what you're doing. But it's clear to me, I don't know how you can help women anticipate the first. It's very, very difficult to give you a good idea about what the pain is like and how you can cope with it. I think we missed the boat and I don't know to get that across. And I don't know if it would be good for every woman to attend another woman. Might be.

V: Interesting idea.

C: Look at her face and hear what she has to say and her groans and moans, just to know what that's like. Perhaps husbands could be helpful here, in that they were the ones who are, at least my husband was the one who heard me say, "I can't do this anymore. This is another one of those contractions and I don't want to do this." And he was the one who heard me express that feeling and he was the one who said, "Now, you breathe. And you can do this. Get a breath and get through this. This one isn't like those other ones, this one's going to be less. You know you can". And he probably could articulate how my labour was from the point of view of knowing me and knowing how my emotions were and my endurance and the things that made me feel like I wasn't going to be able to cope and the things that helped me cope. Husbands who participate in that manner.

V: Do you think there would have been any difference if a woman who'd had had a baby said, "Yes you can. I've done it."

C: Yeah, oh sure. You would expect that the nurse would help you—they were good, but they had other responsibilities with the machines, making sure that was okay. And even the nurse who massaged my back when Nathan went on a short break—she didn't listen as well as she could—or at least didn't observe how Nathan was helping me. Because Nathan put his full weight behind him, and that's what I needed. He pressed, and I'd say "harder." And she was almost ineffectual in the amount of pressure that she put on my back. And I wonder why—maybe she hadn't had a child—but she just missed the boat and I didn't say anything to her. Whereas I think if it had been, say, Mary, the midwife, that Mary would probably be more in tune with what I needed. And certainly someone like yourself who had a child and has experience that way, that you would be more in tune. But the nurse wasn't. Maybe it was that nurse—maybe another nurse would be better.

V: Maybe she gets caught up with her role as a nurse and forgets about her role as a woman.

C: Yeah, and I don't think that's easy. She has responsibilities—looking at my blood pressure and whatever else—she would have to have her attention divided.... It's gotta be individual. Having had a baby and if I was a maternity nurse, I think I would be a heck of a lot more woman to woman supportive than the one nurse was.

V: And yet you said there were lots of nurses.

C: Yeah. The one who attended me in the delivery room was really good. She was in tune with my need to know that I was doing it right, and she kept supporting me in that. I think she was in tune with my need to quit pushing. Nathan was saying, "One more, one more," and she was the one who said, "No, it's okay. She doesn't need to push anymore." And I was so glad to hear that.

V: What I'd like to explore with you is how to look at pain. How to prepare.

C: It sure interests me—the difference or the preparedness I feel for the second labour is miles away from the way I felt I was prepared for the first one. That unknown was truly there when I had those first contractions. And my thought is that, it hits women, those early contractions, "Holy smokes this is a contraction," and they never get over the "yuck."

V: And yet you handled them all very well.

C: And I think it was just if I could do this, I got myself relaxed and I got myself in a good position, with Nathan's hand on my back, I feel like I could do that. And my sense is that for women who have an awful lot of intervention—medication or epidural—you panic at those first contractions and think, "These are the first contractions, what's it going to be like?" and think they can't do this.